House of Commons

Health Committee

The Government's Public Health White Paper (Cm 6374)

Minutes of Evidence

Wednesday 23 February 2005

Rt Hon John Reid, MP, Miss Melanie Johnson, MP
and Dr Fiona Adshead

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Oral evidence

Taken before the Health Committee

on Wednesday 23 February 2005

Members present:

Mr David Hinchliffe, in the Chair

Mr David Amess
John Austin
Mr Keith Bradley
Mr Jon Owen Jones
Siobhain McDonagh
Dr Doug Naysmith
Dr Richard Taylor

Witnesses: **Rt Hon John Reid**, a Member of the House, Secretary of State for Health, **Miss Melanie Johnson**, a Member of the House, Parliamentary Under-Secretary of State, Minister for Public Health, and **Dr Fiona Adshead**, Director, Health Improvement Directorate and Deputy Chief Medical Officer, Department of Health, were examined.

Q1 Chairman: Colleagues, could I welcome you to this session of the Committee on the Government's Public Health White Paper (Cm 6374) and a particular welcome, Secretary of State, to yourself and your colleagues. We are very pleased to see you here again. Would you like to each briefly introduce yourselves to the Committee and then I know, Secretary of State, you want to make a brief opening statement.

Dr Reid: Perhaps I could do the introductions then. This is Dr Fiona Adshead, who is the Deputy Chief Medical Officer, and Melanie Johnson, who is a Minister in the Department, Chairman, both of whom, I have to say, were central (I think more central than myself) to the publication and the work behind the White Paper. You rightly said that any introduction content should be very brief indeed, and I will be. Basically I just want to say that for many, many years we had had discussions about the outcomes we wanted to see in public health, so the consultation and the White Paper is not about the outcomes we want to see. We know that we want people to do a little more exercise, to give up smoking, to avoid obesity, and so on. It was more about how we achieve it, and in particular how we get the balance between encouraging people to live healthy lives and get healthy outcomes and the balance of freedoms that people have to live their own lives. That really was a large part of the consultation. I think that the White Paper consultation we carried out showed a couple of things very, very clearly indeed. The first was that people did not want us dictating to them how they lived their lives and that came through very strongly. On the other hand, they did want three things, I think. First of all, they wanted advice and support to help them make their own decisions, particularly in terms of information. Secondly, they wanted where possible the resources to back them up in implementing the healthy decisions that they made. Thirdly, they wanted protection from the unhealthy decisions of other people, if you like, in the case of smoking for example, and in particular for children. So that is the context in which we published the White Paper and that, as briefly as I can, sets the balance we tried to achieve in the White Paper, Chairman.

Q2 Chairman: Thank you very much. I think it is appropriate to place on record, as I did in the obesity debate two weeks ago, our appreciation as a Committee that the Government has listened to a number of the points that we have made on public health and we appreciate that. Can I begin by asking a question basically about the overall period that the current Government has been in power and my impression very early on was that we, for the first time in many years, as a government took public health seriously. We saw a range of initiatives which were very welcome. Health Action Zones, for example, impacted on areas such as my own in a very positive way. Then I gained the impression that somehow the public health agenda went off the boil, probably towards the end of the last Parliament. Early on in this Parliament we got into debates around targets and waiting lists. There is nothing wrong with that, but it took us away from mainstream public health. We got into debates around Foundation Trusts and we got into debates around choice, basically looking at the acute sector and how people use the acute sector. What guarantees have we got now that public health arising from the White Paper will remain in the mainstream, in the engine room of your health policy?

Dr Reid: I do not think that is an unfair characterisation of the chronology as it happened, because there was a White Paper. Tessa Jowell was heavily involved in it, for instance. But I think certainly when I came in, just less than two years ago, I saw a sequence of things as being necessary to be done. The first was to build up and to continue to build up a huge capacity in the NHS to make up for the years of under-investment. Then it was to introduce the degree of not quantity but quality, and that is where we got into the controversial areas, Foundation Trusts, and so on. But once we had caught up with where we ought to be, or got nearly

to where we ought to be, we then had to look forward and to prevent so many people becoming ill and putting such a drain on the health service. So it was not just a good thing to do, it was a timely thing to do and in fact a necessitous thing to do. That is the first reason why public health will stay in the agenda because we are putting in the biggest ever increases in health in the history of the NHS over the longest period and quite frankly I do not think anyone can reasonably expect that to go on after 2008. There may be increases but they will not be to this extent. Therefore, as Wanless (among others) has pointed out, it is necessary for us to pay more attention to public health, to reducing the need to treat sickness through the public health work. The second reason why I think it will stay in the agenda—provided always that this Government is re-elected, Chairman—is that we are now committed publicly not only to a whole range of general aspirations but to very specific 170 recommendations and very soon the delivery plan, which we will publish, and that will be a public commitment by the Government. That will be impossible, even if the Government wanted to, to withdraw from. So there are good pressures both in terms of circumstance and in terms of our commitment.

Q3 Chairman: One of the problems in politics is that we politicians tend to have short-term goals, inevitably, because we are tied to a four or five year parliamentary cycle and the General Election. How do you see it being possible within the political environment that we all operate in to ensure that public health becomes as big a player in the political ball game as hospitals, doctors, nurses, or waiting lists, because clearly any public health measure which you are taking now may impact in a minimum of 10, 20 or 30 years' time in a way which could possibly (but may not) reflect better on a government of a different party? I have always found this a major dilemma politically, in that public health does not have any real immediate short-terms gains, it is the long-term gain, and us politicians tend to work primarily in the short-term. What can we do about shifting that point?

Dr Reid: First of all, I think in terms of importance health consistently is the most important issue in all opinion polls. Occasionally the economy goes above it or drops below it, occasionally law and order goes above it or comes below, but if you look at the last couple of years health is always at the top. So it is top of people's agenda and it is changing in the nature of concerns about health. You only need to look at magazines, newspapers, and so on. There is far more discussion on what we call public health issues now—exercise, diet, and so on—than there ever was before. So it is there in the public's agenda. The second thing is that I do think, and perhaps this is immodest, that this Government has taken a longer term view of certain important issues than perhaps previous governments. The truth is that we would not be able to put money into the health service, for instance, unless we had taken a long-term view of the economy because for the first two or three years we reduced debt and we reduced unemployment and people were saying, "Spend the money now." We said, "No, we will spend it on reducing debt and reducing unemployment because thereafter in the long-term we will be able to sustain big increases on the health side." I think exactly the same is true of health, and Wanless points that out. If we want to maintain a health service at a good, high level of quality and fast access to people in this country we will have to do two things apart from investing in the health service. The first thing is to shift as much as possible from secondary acute care through to primary and do it in the community, and even before that to stop people having to go to primary or secondary through good public health programmes. So the seed corn of the future of having an effective NHS and funding it is to have an effective public health policy where we lay the seeds now and we will get the benefits, hopefully, in five, 10, 15, 20 years' time. That is why, for instance, we bring in fresh fruit for kids at school. That is not going to yield any benefits for the country, though it will for those children in the next three or four years. But over five, ten, fifteen, twenty years kids who are used to eating fruit rather than chocolate all the time will be a huge boon for the country.

Q4 Chairman: In a couple of months' time, possibly, I may be sitting at home with my feet up watching you guys racing around like idiots fighting a General Election! What guarantee are you going to give me today, without betraying any secrets, that when I am watching the television and the debates between you and whoever from the other parties on health the real issues you are going to be talking about are public health and not solely hospital waiting lists or hospital building programmes? They are very important, I accept that, but what I am saying to you is, are you going to shift this agenda in a way in which in a General Election public health is going to become a sexy political issue in a way in which it has not been for a long, long time?

Dr Reid: I think we have already done that. I cannot remember in my lifetime so many debates and discussions on, say, exercise, fitness, obesity, smoking, drinking, as we have had in the past three or four years in this country. I genuinely think it is at the top of the agenda and I think it will continue there. Even if you were sitting at home with your feet up—which I doubt very much, knowing your proclivities and your energies, Chairman—I will bet that you will have a pedometer on your belt to remind you to go out and do a bit of walking. Even if you do not have that, you will recall that on the television set you are watching there will be an NHS digital programme which will be largely dedicated to advice on health, and next to you will be a telephone where you will think of calling up Health Direct, which we are bringing in, other than NHS Direct. You will then get a whole series of magazines which we are producing, which are largely (though not exclusively) targeted on public health issues, at younger men, at younger women, and so on. So the agenda that we are setting even at this early stage, I think, is to ingrain a recognition of the need to have instruments which constantly bring to people's

attention the benefits of healthy living—without nannying people—protecting those who have to be protected against the irresponsible healthy attitudes (as some would regard them) of others, protecting children in particular, but making sure through the telephone, through the health trainers which we are bringing in in the community and the education programme—which we can speak about because we want to turn all 1.3 million people in the health service into people who recognise public health rather than just treat the sickness. So if you come in, for instance, to accident and emergency they will not just treat your broken leg but if they know it is the third time you have been in in the last year and you have got drink on your breath, without being over-intrusive people may be able to say, "Do you need any help in another direction apart from your broken leg?" So I think we are going to ingrain that sort of thing.

Q5 Chairman: So there is hope for all of us?
Dr Reid: Yes, and one other subject which I was making our views known on this morning in one newspaper is food labelling. We are all very busy people now and when you get off the couch and rush off to buy your food at the supermarket, at the moment unless you have got a PhD in biochemistry and all day, and 20/20 eyesight, you have no idea of the nutritional value of your food. I want to make absolutely certain that busy mums and dads, and even retired politicians, will be able to go to the supermarket and get a simplified form, easily available to them, which indicates the nutritional value of the food they are getting. I have read in certain quarters that we are backing off that. I have to disappoint whatever lobby thinks we are; we are not. I am open about the format. I do not care whether it is 1, 2, 3, or A, B, C, or the colours of the rainbow, but we are going to have food labelling for the people of this country and if we cannot get it voluntarily here then I have already opened discussions with the European Commissioner on it and we will be pursuing a European-wide measure on that. So public health is here to stay.
Chairman: We will probably touch on that particular issue in a few moments. Jon.

Q6 Mr Jones: Thank you, Chairman, and you are welcome to come down to Cardiff with your pedometer—as you are, Minister. I want to refer to the Wanless Report. Wanless asserts, Minister and Secretary of State, that better public health will save the National Health Service money. Do you agree with that assertion and do you agree with the spending projections, the different projections of potential savings which could be made according to Wanless?
Dr Reid: I agree with the general point and I met, obviously, with Derek Wanless on this and as I indicated at the beginning, I do not think this is an add-on in terms of the future economies of health care in this country; it is an essential ingredient in making sure that we have got a sustainable long-term health care system. I would make one qualification for that: whatever we do in health, if we are successful it brings us bigger challenges because if we are successful people live longer in greater numbers and therefore have to be taken care of longer. Having said that, I do agree with Derek Wanless. The real question becomes, I suppose, to what extent you are willing to curtail people's freedom to have their own choices in life in order to reach the outcomes which give you not only the maximum health benefits but the maximum economic efficiency in the provision of health care. That is why I said at the beginning, Mr Owen Jones, that there is a balance between the two. But in general I agree with Derek Wanless.

Q7 Mr Jones: You anticipate the next question. My next question is, in the scenarios that Sir Derek describes he describes the fully engaged scenario. A fully engaged scenario has a target, according to Sir Derek Wanless, of 17% of the general population smoking by 2010, which is the current level in California. You have rejected this target in favour of a less ambitious one. Other than enabling more choice, do you have any other reason for that?
Dr Reid: The first thing to say is that some of the targets that we have put out Derek Wanless regarded as over-ambitious and some of the targets he thought were less ambitious than they ought to be, though more ambitious than the ones be criticised four or five years ago, particularly in the case of smoking. The fact of the matter is that I doubled the target reduction for smoking because we were going to reduce it originally down to 23%. I doubled that, and secondly I put a very important proviso in it which I think is as important as anything, and that is that reduction should apply to all social classes. That, to me, was as important as achieving a reduction, which was basically middle-class people giving up smoking. So contrary to what you may have read in the press, I want to make sure that right across social classes we get that reduction. Now, when you reach a decision as to how far you can go the important assumption which is built into the White Paper on all sorts of issues is that you cannot achieve and get towards what Derek Wanless in this country by direction. It is not acceptable to do it by direction because if you are going to achieve all of these targets by direction then you would not get to the stage where it was compatible with the sort of mature adult lifestyle and life choices which people in this country want. So where we introduced the target in smoking, it was what I thought was realistic to get it down to around 20%, which will have reduced from 48%. Other countries have taken a more stringent view on, if you like, the prohibitive side of things. In Scotland, for instance, they have decided to go for a complete ban on smoking. I came to the conclusion that that was not a good thing on health grounds, apart from anything else, because you get a displacement of smoking from some pubic areas to the home—and most of the evidence about passive smoking is about the home—but in any case if you look at the reduction we have had in England in smoking in recent years, the figure we are at now is higher than the reduction in Scotland. So it is a matter of getting a balance between what we felt was

reasonably achievable—and not just in smoking but across a whole range of areas. The fully engaged scenario of Wanless would in some cases require a degree of government dictation to you about your life which is not acceptable in modern Britain, in my view.

Q8 Chairman: Can I just intervene? We are going to talk about smoking in some detail later on, but just to clarify, you made the point that in Scotland you were concerned that banning smoking in pubs would displace it to the home. Have you got some substantial evidence to prove that, because certainly there are people who have put to us the alternative argument that many people who smoke do so only when they have a drink and if they did not smoke when they were drinking in a pub they would not smoke at home?
Dr Reid: That is anecdotal when people tell you that, I am sure, because I speak with some considerable experience of smoking and drinking, if you do not mind me saying so. There are not that many people who endanger their lives hugely by smoking only when they go out to a pub and the truth of the matter is that we do not have a great deal of evidence on that because there are not that many places where we have had long-term prohibition of all smoking outside the home, but what we do know, for instance in Ireland and we would anticipate in Scotland, is that a %age of people who previously went to the pub to smoke will now get a carry-out and take it home. I think the %age in Ireland is about 15%. That is not the primary reason for reaching the decision I reached, Chairman. I reached my decision on smoking because I felt that we had achieved a balance between protecting the public who did not smoke and who wanted a smoke-free atmosphere—and the legislation was introduced to protect the public, not to force you to live a certain lifestyle because if we do that and force you to do that which remains legal we start on a whole series of questions like why should we allow you to box, or drink, or whatever and then still be treated on the health service. So the primary purpose for which I brought in the legislation was to protect people from the smoking of others, that is passive smoking, but in addition to that I am saying as an observation (it was not the primary reason why we did it) it is also my view that there will be a displacement if you allowed no smoking in any public place whatsoever. In our case we have got 90% of pubs and restaurants which will be non-smoking, but there will be some areas. So if you allow none whatsoever there will be a displacement (as in Ireland) from people who previously went to the pub who will take drink home. Now, I assume they will smoke at home and most of the passive evidence we have got on smoking is based on people who live with smokers. So that is a secondary point.

Q9 Mr Jones: Can I come back, because this conversation you have just had with the Chairman illustrates one of the most important parts of the Wanless Report, which was not about specifying what we should do but specifying how we should do things and how we should make choices about what we do. Sir Derek Wanless stated that measures to improve public health should be based on considerations of evidence and cost-efficiency. In that discussion you were assuming that evidence from Scotland would show something—
Dr Reid: But I think there is something missing from that quote. The decision about how you dictate to people about how they live their lives has to be based on more things than just evidence and efficiency, it has to be based—

Q10 Mr Jones: If you will allow me, I am accepting the argument that we have to make this balance. I am only trying to explore a different argument about when you are balancing what works and what does not work you can take into account whether you should or should not do it for reasons of choice but you still need to have a sound evidential basis for deciding, does this work anyway? He expressed a dearth of evidence on the cost-effectiveness of many, many programmes. Do you accept that there is an argument that there often is not evidence?
Dr Reid: I do not accept it on the main one because my memory is that, ironically the main one is that he did not think smoking cessation services—

Q11 Mr Jones: No, no, forget smoking. I am not talking particularly about smoking.
Dr Reid: That was his main one, as I remember. I will stand corrected. But on smoking cessation services, I believe they are very effective. I think we have got another 240,000 people in the last year who gave up smoking.

Q12 Mr Jones: We will ask questions about smoking again, but I am just trying to ask you about the methodology, not—
Dr Reid: I am giving you an answer. No, I do not accept his view that in some of these major areas on which we have based our proposals in the White Paper, including in areas where he thought there was insufficient evidence, we have not had the evidence. I do accept in the question the Chairman asked me about the future that I do not have the evidence on that, and that is why I made it plain it was not my primary purpose. I do think we should base it on evidence, that contention I agree with, but some of the conclusions he then reached about some of the services which were directed towards public health not being evidentially based I do not accept.
Mr Jones: Let me give some specific examples, and I am going to move away from smoking. I am sure others will raise smoking questions later on. The Chairman quoted approval for Health Action Zones. I am not aware of the evidential basis or the cost-effective basis for Health Action Zones, and if there is a good evidential base and a cost-effective base then obviously we should be continuing with that.
Chairman: Jon, can I just say I quoted the example of one constituency where I saw some very positive developments.
Mr Jones: Anecdotal information.

Chairman: Anecdotal, what I saw up in the schools. That is what made me feel that it was a positive initiative at the time.

Q13 Mr Jones: Nevertheless, the point is there was an initiative, Health Action Zones, which does not exist any longer. I am not saying whether that was a good initiative or a bad initiative, but has the Department conducted any work to establish an evidential base and a cost-effective base for this? Did it work cost-effectively or did it not work cost-effectively?
Dr Reid: The answer to that is—and I will try and wrap it all together—I agree with the challenge that these should be evidentially based. I disagree with some of the comments you made about specific areas. There are some areas on which we do not have evidence, and if you look at the White Paper what we propose, and certainly what we are doing, is evaluating evidence now. For instance, on drinking we are doing an audit of both treatment and identification of drinking. I would have liked to have gone further but in some areas there was not the evidence that we needed. In the case of Health Action Zones, which you mentioned, we are now carrying out an evaluation of the cost benefits of Health Action Zones.

Q14 Mr Jones: Will the Committee be able to see that?
Dr Reid: If I could take advice on when we would expect that.
Miss Johnson: Ken Judge has carried out an evaluation of Health Action Zones for us and we could give you the information and the evaluation report within the next couple of weeks, I am sure.

Q15 Mr Jones: Excellent! Can I turn to another initiative which, Secretary of State, you mentioned earlier, health trainers. Is there any evidence for the cost-effectiveness of health trainers?
Dr Reid: Yes, the fact that lots of people spend lots of money on it.

Q16 Mr Jones: That is not evidence for the cost-effectiveness.
Dr Reid: Is it not?

Q17 Mr Jones: It is evidence that people can be persuaded to spend a lot of money. There is a lot of things in the market that people spend a lot of money on which are not necessarily effective.
Dr Reid: In health terms?

Q18 Mr Jones: In health terms, yes.
Dr Reid: Like what, for instance?

Q19 Chairman: Cosmetic surgery?
Dr Reid: That is not really down to health and we do not provide that on the NHS precisely for that reason. I say this in half-jest, Mr Owen Jones: most of the times that people pay money for in health is access to gyms, sports equipment, involvement in various sports (skiing, running, and so on) and in cases where they have sufficient money personal trainers to give them advice on training routines, and so on. Most of these things appear—and I do not have the statistical evidence in front of me to illustrate that this is intrinsically a good thing, but most of this seems to me a good thing. The evidence is being supplied to me from left stage even as we speak and if I was sufficiently educated to read very good writing I would be able to tell you. "Peer education works," it says here. So if you have a trainer it helps. Now, look, this is based on a very simple hypothesis which I think there are generations of evidence for, and that is if you want to live a healthy life and you have access to support, encouragement and information, you are more likely to sustain that healthy life than if you do not.

Q20 Mr Jones: I do not object to that. Every now and again you have to have a punt and it may work. It may be one thing to do something when you do not have a lot of evidential basis but you think it may work, but even so you should be then measuring whether it is working after you set it up.
Dr Reid: Yes, absolutely.

Q21 Mr Jones: In the same way as the Health Action Zones may or may not have worked, will you be measuring this?
Dr Reid: Yes, we will, and the process of evaluation on these—

Q22 Mr Jones: Can the committee know how you are measuring it?
Dr Reid: Yes. Fiona?
Dr Adshead: There is evidence that community-based educational models work. There is also some evidence that psychologically-based behaviour change models around smoking work. There is evidence around our smoking cessation services. There is also some evidence around health eating and exercise that these approaches work. We are currently developing a health training model and as part of that we are working with a group of academics to build a valuation in and we are going to be building a valuation in throughout the programme so that we get real-time evaluation, because one of the problems with the Health Action Zones was that the evaluation came in some years after the programme had started. So this time we want to learn as we go along.

Q23 Mr Jones: Sir Derek Wanless had something to say about how you establish evidence as well and he said that there had to be a body independent of the Department to analyse evidence, in his words "to develop the cost-effective evidence based on public health". The Health Paper rejected that recommendation.
Dr Reid: No. We have already got the National Institute of Clinical Excellence, which now has a world-wide reputation for evaluating treatments and we intend to ask it to evaluate some of these things. Others will do internally as well, because we have got a Health Information and Intelligence task force, believe it or not, which is looking at both new ideas and the evaluation of the ideas.

Q24 Dr Naysmith: Just before we leave this sort of philosophical area we are in at the moment, the philosophy underlying the White Paper and public health, we had some evidence given to us by the Association of Directors of Public Health (this was written evidence, we did not have a chance to question them on it) and they rather welcomed the White Paper on choosing health and its focus on lifestyles and individual choices, which we have just been talking about. They then went on to say that health improvement does need to also address the importance of the underlying determinants of health, things like poverty, educational attainment, housing, social networks and deprivations like that. They are obviously of the view that not enough attention was paid to that area, which goes back, as you know, because we have discussed it before, to things like the Black Report, and so on. Why can they make that criticism, and what do you say to it?
Dr Reid: I find it bizarre, Dr Naysmith, and the reason why I am laughing is that since about 1844 some of us—I have not been around that long, but the traditions from which I come believe that a lot of people can make choices through their own free will but people do not make them in circumstances of their own choosing or circumstances equal to other people, and therefore some people in more deprived circumstances will find it difficult to change their lifestyle. When I pointed this out with reference to smoking, perhaps a young single mother with very little money, in debt, with four kids on a sink estate, and so on, and said that she might not find it as easy to change as someone else, I was attacked by any number of people from the public health field for stating precisely what you have just stated, that if you want to help people change, whether it is diet, lifestyle, or whatever, you have to help them change their social circumstances. Therefore, far from being the person who ignored that, I was the person who was championing it even in the most controversial of areas. The second thing is, that is precisely why—

Q25 Dr Naysmith: I understand that. What they are saying is there is not enough about it in the White Paper.
Dr Reid: I am just going on to tell you. This is precisely why we had the biggest exercise in cross-government collaboration—it may be that you think it should have been even bigger—with the Office of the Deputy Prime Minister on housing, the Secretary of State for Education in terms of the protection of children and foodstuffs, and so on, with Tessa Jowell on exercise, right across the spectrum and for the first time ever enshrined that in a Cabinet Sub-Committee chaired by me, MISC 27, which is still extant and will continue on putting through the delivery of public health. So we are trying to do that. It may well be that people feel we should have had more cooperation in changing social circumstances, and if so I welcome that because that is exactly where I am. I want to say that we must encourage people to choose healthily. We cannot dictate to them but one of the most important things we can do, as you said, is change the circumstances in which they live. To put it crudely, if you want to increase the chances of people giving up, say, smoking, make them middle-class and you will find that as horizons extend and opportunities and other things extend to them if you look at the statistics you will find that the smoking drops. So you do not just give them help directly on the question, you do not just give prohibitions but you change the social circumstances. That is the converse of that statement, for which I was castigated by many people.

Q26 Dr Naysmith: The second point which comes out of the Directors of Public Health Association is that they also say that not enough is made in the White Paper of preventative programmes such as immunisation and screening. I know your answer will be that there are other parts of the Department who are doing that and looking at it, but in order to tie together the whole of public health you have to sort of link it all together?
Dr Reid: I will ask Melanie to come in on that, but just to say first of all that we had to decide at some stage the limits of the envelope and there were things like environment, toxicity, and so on, which were independent of people. We decided that the limits of the envelope should be basically on those issues which could be changed by people changing their own lifestyle rather than by changing external things in the main or having things done to people.
Miss Johnson: I think my list of responsibilities, if you exclude the coronary heart disease and cancer, things which are not only public health but wider, is about some thirty-odd topics and obviously only about a dozen of them are represented here. They are all very much mainstream public health, including obviously things like vaccination and immunisation. But they are not things about the lifestyle choices generally that people are making, they are about the wider programmes of public health, and we decided to concentrate on really what in a sense is a most difficult area of public health, namely the areas in which the choices of a lot of individuals determine whether we are a healthy nation or not and the circumstances under which those choices are made. I think it is the most difficult areas that we have focused on. We of course recognise all the other areas which play a very crucial role in public health and which will continue to play that continuing role, in which regional directors and others still have very important roles to play.

Q27 Dr Naysmith: Thank you. The final point on that is that keeping things like that outside of the White Paper, and people thinking this is the Public Health White Paper, may mean that there is not specific money for some of these things which are not in the White Paper and people will see what is in the White Paper as a high priority and things which are not in it may find themselves having to fight with other bits of the budget to get that?
Miss Johnson: We have, for example, at additional extra cost, just introduced recently the five-in-one vaccination, an improve vaccination for children, so we are doing things that are still costing us extra money. We are still doing things to develop all of

those programmes. We are looking at the pneumococcal side of things now as well. All of these things are developments. We have increased markedly the take-up of flu vaccines amongst the over sixty-fives and in the under sixty-fives at risk. All of those programmes continue to march forward at substantial extra cost as part of the general circumstances, the general environment in which lifestyle choices are being made and where we focus the White Paper on those particular issues.

Q28 Dr Taylor: I think most of us will welcome the White Paper tremendously, particularly the recognition that prevention is better than the cure and it is cheaper than the cure, but because the health service is really by habit a sickness service there is a tremendous problem at PCT and Trust level making relatively small expenditures on prevention which in the long-term will save vast amounts of money elsewhere in the health service but not for them. Have you any comments on that? How can it be made easier to spend the money on prevention, which will not save money immediately but will save money for other departments, other parts of the health service later?
Dr Reid: I think that if you see this in the context of the development of the National Health Service, Dr Taylor, you will see that there will be either pressures or determinants that are shaping people in this direction. The trend that I mentioned earlier, which is the encouragement of people to try and treat illnesses in the community at primary care level rather than at hospital, I think will be accentuated by people at the local PCT level recognising (and indeed GPs recognising) that if you send everyone to hospital then they are going to have very little money for anything else. The more you hand responsibility down to the local level, and that will happen year on year up to 2008—it is not uncontroversial; we have had discussions on this, on various forms of it—the more people take responsibility for that allocation of that money, their own priorities, and it will obviously make sense to treat people in the community rather than in hospital in many cases as much as you can. It is also obvious to us and to you, and I think will be increasingly obvious at the local level, that the saving of money by prevention rather than cure (as you put it) is a good medium and long-term benefit for the local area. Now, that is the first thing. The structures we are putting in place I think will encourage that. The second thing is that we intend throughout the National Health Service (for purposes which are not that but incidentally will assist in the question you asked) to try and encourage as part of the culture change of the NHS the 1.3 million staff rather than just to treat the sickness that they all treat in their own ways an early identification of preventative opportunities. I gave one specific example earlier on which was about drink but it could be in a whole range of areas, whether smoking, lifestyle or obesity, and so on. If we do that then I think that will have a rub-off effect as well at the local PCT level.

Q29 Dr Taylor: Can I take you back to alcohol specifically? Various Members were not very keen to take on the questions on alcohol!
Dr Reid: There are no declarations of interest made!

Q30 Dr Taylor: No, no declarations of interest. We have been told that alcohol consumption across Europe is falling but in this country it has doubled in post-War years and illnesses, particularly cirrhosis, have trebled between 1970 and 1998. These are figures from Sir Liam Donaldson. There is the worry that not only is alcohol linked with cancer of the liver but certain other cancers. We are not really quite clear what measures proposed in the White Paper will reverse this trend because this is really a preventative measure which should not cost much.
Dr Reid: First of all, I think you are right in the emphasis that you place on this, Dr Taylor. I myself was interested that in the whole of the debate we had about the consultation out there we had a huge amount of controversy and discussion over smoking and hardly anybody in the press was interested in alcohol. I was trying to say that smoking was not the only issue that was facing people and I asked for some figures in the course of our discussions. There are at least one hundred and fifty thousand hospital admissions every year. I think it is probably true that 75% of people in prison are there as a result of violent offences, alcohol-related. There are at least fifteen to twenty-two thousand deaths a year caused through alcohol and the estimated cost to the NHS every year of alcohol-related illnesses is of the order of £1.7 billion, which coincidentally is the estimated amount, I think, for smoking-related illnesses as well. So it is a very serious subject indeed.

Q31 Dr Taylor: So what are you doing about this?
Dr Reid: One of the problems we had in taking as well defined measures on it—and you are entitled to ask that—would I have liked to have gone further and done more? The answer is, yes. Why did I not? The answer to that basically is related to what Mr Owen Jones asked us earlier, and that is that the evidence on how to identify and how to treat, and so on, and what treatments were available, was not as well developed as in many other areas. So one of the first things that we are doing—and you legitimately asked us what are we doing about it—first of all, this is the first time we have got a coordinated strategy for alcohol, the Alcohol Reduction Strategy, which I can go through if you want. Secondly, as a result of discovering the lack of information really that was available to us during a consultation, we have undertaken a national audit of the demand for and provision of alcohol treatment and this will provide, I hope, a comprehensive picture of the current availability of treatment and it will highlight the gaps in supply of treatment. I will receive that report later this month and I think that we will be able to send it soon thereafter to yourselves should you want that, Chairman. It will be followed up then by what in the management jargon is called "a local tool-kit" that will allow access to local need. The National Treatment Agency will be publishing models of care in alcohol guidance on the

organisation of alcohol treatment in our review of treatment effectiveness and that piece of work and the results of the national audit will provide the foundation for the very programme that you are calling for. So yes, I would rather we had been able to do this earlier. Yes, you are right in the importance I believe is placed on it and sometimes is not outside where drugs and smoking get much more of the attention. It will also benefit partly from what we call the "pill treatment budget" which is distributed to drug action teams throughout the country and from May of this year the Department of Health will be piloting a programme of targeting, screening and brief interventions, giving short-focused advice and guidance to those identified as being at harm from alcohol abuse as it arises in the course of other treatment inside the NHS. I could go on and describe various other things. With the Portman Group we are engaging the industry—

Q32 Dr Taylor: With respect, Secretary of State, I am trying to get at it earlier than alcohol problems that require treatment. The Health Development Agency says quite clearly that the only effective method of really tackling harm is to restrict the availability of alcohol and the first one would be a very unpopular measure but it would be to raise taxation and raise the price. That appears to be perhaps the only really effective method of reducing it. What is the Government's views on raising taxation on alcohol?

Dr Reid: On the first one, which is how to tackle it—if I can divert just for a second, Chairman—you may not know, Dr Taylor, but when Kier Hardy published his first manifesto in 1894 the first demand he made was that there be home rule for Scotland, Wales and Northern Ireland, which has now been delivered. The second demand he made was that there be a minimum wage, which has now been delivered. The third demand he made was the end of hereditary power in the House of Lords, which is now delivered, and the forth was a ban on the production and sale of alcohol. We did consider putting that to a commission of the Scottish Labour Party to decide how much action we should take and how quickly on it, but we have no plans for that and I would not like anyone behind you with their pens to start running on it! On taxation, we leave that to the Chancellor. I note what you say on that, but matters of taxation are for the Chancellor. However, it is true that sensible drinking requires the engagement of the industry and the Portman Group, which operates with the industry. We are engaged with them on this. Do I think that we are all doing enough on this, including Government and industry? No, I do not. Do I think that the audit that we are carrying out in terms of treatment, which includes early identification as well, will tackle the problem? No, I do not. Do I think that the amount of persuasive marketing and advice to people to drink sensibly is in any way a counterbalance to the amount of general persuasion to drink out there? No, I do not. If you ask me, avoiding taxation, what I think is the solution, there are several levels of the problem. There are people who drink at home, perhaps silently, and that is an obvious problem. Then there are the people who are reasonably affluent, though maybe young, who are involved in binge drinking. Then there are not so much the people who binge drink in pubs, bars, and so on, but who drink the cheap fortified wine or other cheap drinks in areas that I am sure some of our colleagues here represent, which is a problem, on street corners, and so on. So we need a much more comprehensive strategy for dealing with those things and I hope that the audit we are carrying out will be the beginning and not the end of the action that we take on it, Dr Taylor.

Dr Taylor: Thank you.

Q33 Chairman: Could I just ask a question? Going back to the point about the limited amount of responses on alcohol on the consultation on the White Paper, I was very struck and I think the Committee was struck when we were looking at obesity at the very limited evidence that we received on the connection between alcohol consumption and obesity. I think this is an area of great interest. It seems fairly obvious to one or two of us that there may just be a connection there, but why is it in terms of a society we do not seem to be doing anything about it? We do not seem to have that response that you would have expected in putting out the proposals that you were considering.

Dr Reid: You are asking me a question which I will immediately be challenged on by Mr Owen Jones as to my evidential base. I can give you my own view on this. I think that people do not think of the passive damage from alcohol the way they think of the passive damage from smoking, but the passive damage from alcohol is enormous: the number of people who are killed in drink-driving accidents, the number of people who are injured through drunken violent incidents, the number of people who are in jail and the cost to society of that through alcohol-related problems. It is sometimes on a Saturday night sixty to 70% of people in accident and emergencies being paid for by the state come there as a result of alcohol and yet it is an integral part of our lives for most people because they do not abuse it. Most people do not abuse it and also used in a sensible, entertaining, social fashion it is a fantastic addition to the social life of all good, healthy, sensible people. Whereas things like smoking one cigarette damages your health, one drink does not damage your health. So it is a much more difficult thing, Chairman, to classify as entirely detrimental to health because it is not. Drinking a few glasses of red wine is very good for you and from where you come from drinking a few glasses of beer is regarded as good socially as well as on the health side. So it is harder, I think. My own view is that if we are gong to tackle some of these problems, particularly with young people, the only real solution—and you mentioned tax—is to make it uncool because I do not believe that prohibition and curtailments, and so on, work on these things because sometimes for young people that has the disadvantage of making it appear cool rather than uncool.

Q34 Chairman: Richard, it struck me that we have got your second election pledge that you are going to increase the tax on alcohol. Is that right? The first one was that old people should clean up graveyards! The second pledge. Over to you.
Dr Reid: I did notice that. I think it is a contribution to the General Election campaign that the Liberals have now pledged, and David has now pledged, to introduce a tax on—what was it, a doubling of the price of beer?
Chairman: Go on, Richard! Over to you.

Q35 Dr Taylor: I am moving off that subject but going on with reducing the availability of alcohol, which really seems to be the only way of cutting the amount people drink. Another way would be restricting the hours and the days of sale. I should think most MPs have been approached by constituents with the worries about garages selling alcoholic drinks way on into the night. So at the moment it is incredibly easy to buy alcohol at any place. Have you any plans to reduce the availability by restricting the sale in any way?
Dr Reid: I will ask Melanie to respond to you, but if I may just say something first of all, Dr Taylor, because it gives me the chance to counter the myth that the recent Licensing Act was only about extending the flexibility of hours. It was not. It brought in a local accountability element because local councillors rather than just those connected with the local judiciary have a power and responsibility and it brought in a range of restrictions which could be more effectively and more speedily implemented to premises where there were abuses of alcohol sales or use going on. So on your question, "Have you any plans to bring in some form of punitive or restrictive measures in law?" yes, we have brought them in actually. We brought them in through the Licensing Act brought in by the Secretary of State—I cannot remember who it was now. When they were brought in most of the coverage that was received in the press on this was on the flexibility of hours and missed out the fact that we were bringing in some fairly punitive and restrictive potential measures which could be applied at a local level.
Miss Johnson: First of all, just on the cost of alcohol point, before you enter it into your election pledges and on the evidence-based question, looking at Continental comparisons you would not necessarily draw the conclusion that you seem to be coming to about the sensible use of alcohol and taxation levels. So I simply enter that as a caution into your thinking. Secondly, if I may go back to the behavioural points again a little bit more because when we think about drinking and driving or wearing a seatbelt, for example, a huge change has been brought about in general public acceptability, as the Secretary of State is saying, in terms of what people are prepared to do, what they think is right, by public campaigns to educate at the end of the day. The vast majority of people have bought into those campaigns. They have been hard-hitting, they have been long-term, they have been repeated and they have targeted the points that people are most sensitive on. I know from talking to the Portman Group, for example, they have run some advertisements, which you may or may not have seen but I am sure they can supply you with a video of them if you are interested, which are aimed at young drinkers. The picture of them is that they are out of control and they know from the research they have done that young people do not like the notion of being out of control.
Dr Reid: It is uncool.
Miss Johnson: That is not the picture that they want to see of themselves. So targeting things like those sorts of areas in terms of behaviour change I think is very important and we will be working more with them. But also on the point about the more punitive sort of restrictions, and so forth, there is an important place for those and that is why on cigarettes we have said we are clamping down on under-age sales. On alcohol, the Licensing Act already has a number of measures in it which does that. It makes it an offence to allow any person under sixteen to be present in licensed premises exclusively or primarily used for the sale of alcohol unless accompanied by an adult. Between the hours of midnight and 5.00 am it is an offence for somebody under sixteen to be present on those premises and for the first time it makes it an offence to sell alcohol to people under eighteen anywhere in England and Wales. I think we want better enforcement as well coupled with this, and certainly the Home Office and ourselves are very committed to seeing that better enforcement in place. I think these are part of the measures, coupled with a much better education, which are important in tackling the issues that we face. We are working on a new sensible drinking message which will be available later on this spring. I think spring in this case is a bit of an elastic season, as I have often found the civil service does have an elastic season for spring. It will produce a new sensible drinking message. It will be unit-based still because we know that there is still a degree of understanding of the unit-based analysis, as it were, of alcohol. But we need to think about how we get those messages across, how we reach the right audiences and really stepping up by a significant amount our efforts in getting those messages across to young people, particularly from mid-teens through to mid-twenties because that is probably the age group which is most affected by these issues.

Q36 Dr Taylor: Do you think you will be able to have any effect on those slightly older drinkers who are drinking far more than they should and for whom the extended drinking hours will make that even easier?
Miss Johnson: The extended drinking hours are a matter for the local authorities and I think the evidence is, if you are talking about the 2003 Licensing Act, that at the moment many places are not extending significantly their drinking hours. But it is a matter for local authorities. So if there is disruption, disorder or other consequences being seen in the locality, local councils now have the power to take not only short-term, immediate

punitive steps by closing premises but also longer-term steps about the future of the licensing arrangements. So there is a considerable panoply of powers at a quite local level to reflect local behaviour, local need and a local view about what is necessary in dealing with the issues.

Q37 Dr Taylor: So my local ambulance drivers, who have been approaching me with their alarm about the increased use of ambulances for drunks with the increased length of drinking hours should be approaching their local council?
Miss Johnson: Indeed. The local council has all the powers now to deal with that on a local basis, and much stronger powers than the magistrates would have had previously under the old arrangements.

Q38 Siobhain McDonagh: If we can look at the kind of licensing rules, there are suggestions that while the local authorities do have more powers now, they are given a very strong set of guidance which is restricted and the alcohol industry will also be able to appeal to the courts if they do not get the decision they like from their local authority. Are local authorities in theory able to determine the number of pubs to give licences to, who to choose and who to close down, but in practice have their hands tied by Government guidance?
Miss Johnson: I think the point about the licensing arrangement is to give local decision-making. If at the point at which decisions are being made there is not a good justification for it in some shape or form, the fact is that most councils, I think, will be trying to make their judgments on the basis of good evidence. I used to be a magistrate at one time and I have sat and made licensing decisions and I know limited information ever came to the magistrates generally and very little often was done at that level to change practice. There was certainly no overview of the community because it is a licensing by licensing decision. The councils can now take a much broader view than that, and I think for the first time they have the powers to affect things in a way which will be positive. But that is not the main thrust of what we are trying to do on public health. The main thrust of what we are trying to do on public health is to identify those who are at risk from alcohol. So, as the Secretary of State has already said in answer to an earlier question, those who turn up a couple of times at A&E who have clearly been drinking will be identified and the right ways, the sensitive ways of dealing with that and suggesting that they may want to get treatment or to see somebody to talk about sensible drinking will be put in place, and we are looking at how that can best be done through, for example, the initial contacts in A&E through to other services. Secondly, we are working on all of this area of sensible drinking and the binge-drinking culture, which I think is the thing that most concerns the public now, although I am sure, along with Members of the Committee, you will have all had contacts from a lot of the consultants who work with those who are affected by long-term drink and the effects of long-term drink on various aspects of health who are concerned about that. We share their concerns, but I think often that is where the treatment services and the audit that we have put in place is important because those people may need longer term support to give up their drinking. It is not just about the sensible drinking message. If you are a long-term, very serious drinker, you will in effect have an addiction of some kind and you need the sorts of supports for alcohol that we have been providing for drugs for some time, and that is being done on a much more systematic basis with the same sorts of standards being introduced and a much greater look at where the services are, what treatments are available, what works and how we develop that in the future, with some money behind it in the White Paper which we have put in here for that.

Q39 Siobhain McDonagh: Thank you. Several submissions to the Committee have expressed surprise at the White Paper's identification of the Portman Group as the sole named non-statutory partner in the Government's response to alcohol problems, not least because its record has been severely criticised in the scientific press. Why do you involve the Portman Group but ignore reputable medical bodies which are free of drink industry connections?
Miss Johnson: We are happy to see anybody who would like to meet with us and forward this agenda. Obviously in the case of the Portman Group they have money at their disposal as a result of the industry funding. We are certainly looking to them to make a bigger contribution on getting across the right messages about alcohol and drinking and playing a much more responsible role with us in encouraging the responsible use of alcohol in our society. I met a colleague of all of ours (I will not say who it was) who brought some consultant from her local hospital in to talk to me recently, to share experience and talk about the nature of the work that was going on and that she was aware of in relation to alcohol-related illness and demands on the health service. So we are always happy to receive input and to have a dialogue with any of those interested in tackling these problems.
Dr Reid: I think the point to make in direct response to the point you make, Miss McDonagh, is that we want to work with anyone from the voluntary sector or anywhere else who wants to help us to combat irresponsible drinking which damages people's health and damages other people's lives, but we identify the Portman Group because they were related to industry, because we do believe that the industry has a responsibility here, a responsibility which will not be discharged only through the Portman Group but could be discharged through the Portman Group if it was more active and better funded. So we will be encouraging that in that direction. So ironically, we chose it. People may say, "Why are you only choosing this?" We are not only choosing this. We say, okay, if this is the vehicle through which the industry wishes to tackle some of the messages they want to put across then we will work with that and encourage it to be better funded and more active.

Q40 Dr Naysmith: Can I just check on what you have just said? Are you saying that if the Portman Group had more funds available to them they would be able to do some things that you would like them to do which they currently cannot do at the moment because they have not got enough money?
Dr Reid: Yes. We have been talking to them on precisely this. Look, you do not have to be a genius to work out that the amount of money which is spent directly by government, by individuals and by companies (including companies which are involved in the drinks industry)—and I do not for a moment forget that they pay a lot of taxation—

Q41 Dr Naysmith: They also make quite a lot of profit, too, and they have got double or treble the amount of money you will spend tomorrow.
Dr Reid: They may a lot of profit and pay a lot of taxes, indeed. To be fair to them and in the objective account we recognise they pay some taxation. However, I think that if you look at the amount of money that is spent on promoting drink—perfectly legitimately, I do not have any complaints with that—and the amount that is spent on promoting socially responsible drink and the avoidance and the warnings about irresponsible drinking, there is no comparison between the two. What we are doing is we are engaging with the industry. I hope it will be constructive. It is only recently that we have started to get intensely engaged with them, but we are engaged with them in saying, "Look, help us to make sure that you can have a flourishing industry, people can have a flourishing social life, but we can reduce the binge-drinking or the unhealthy drinking." Part of that, and that is what I am saying to Miss McDonagh, is through the Portman Group. They can discharge that, we think, with a little more money and a little more activity.
Chairman: I know Keith wants to come in on smoking, but before he does, on the issue of alcohol can I refer to the gender aspect of this because one of the things which certainly concerns me is that I have got children, one nearly twenty and one seventeen, whom occasionally I have to pick up late at night from the city centre and it is very apparent to me from my time when I was their age going out in the city centre pubbing and clubbing—
Siobhain McDonagh: Did they have cars then?

Q42 Chairman: Thank you, Siobhain. There has been a fundamental change, in that although the male behaviour is not dissimilar to what it was when I was their age, you see far more girls out and in sometimes terrible states. What are you doing to look at that aspect of your alcohol strategy, the gender aspect, particularly the number of young women who do drink excessively and become incapable as a consequence? That does obviously tie in with some of the concerns that we have on the sexual health inquiry about the link between alcohol misuse and sexual problems.
Miss Johnson: Just to go back, I do not want to dwell only on what the Portman Group has done because the sensible drinking messages will be rolling out, as it were, and we will be campaigning. There will be leaflets, there will be web stuff and other things going on from later on this year. But what the Portman Group has done, for example, is that the ad which is run uses young women and it is young women in particular being out of control as a result of alcohol, which is something which they know young women in particular do not like to be. So we have got to get back to that.
Dr Reid: The simple answer, I think, to your question is that we understand that in any information, education campaign, whatever, persuasive campaign, the messages in it have to be appropriate to the gender. There are certain things which will work better with young women than with young men.

Q43 Mr Bradley: I do want to go back to smoking, you will be pleased to hear, Secretary of State, and not the census in Manchester! Can I just preface my remarks by just commenting on some of the answers on alcohol. I very much welcome the fact that you are undertaking an audit of services. As part of that process will you be disaggregating your expenditure and as a consequence other departments' expenditure between the amount of money that is spent on alcohol services and programmes as opposed to other misuse of substances? What I have found is that they are often in an aggregate pot and there is a disproportionate amount of money, money that is well spent normally on other substances and not on alcohol, and there has always been a sort of blurring of that so there is not the focus on alcohol programmes that there ought to be. I know from my own constituents we have had to battle to keep alcohol services. We have just opened a new alcohol treatment unit, which you would be very welcome to visit, but it has been a battle all along because alcohol has been low on the list of priorities as opposed to other programmes in this area.
Dr Reid: Yes, certainly. We are just discussing what it was because we have got a figure of £15 million here, but that is additional. The expenditure disaggregated on alcohol is about, from memory, £95 million. You may argue that that is too low, too high, or whatever, but we now know roughly what it is.

Q44 Mr Bradley: That is the important point. We know now what the baseline is.
Dr Reid: Yes, and we think that ought to be spent. But that is not ring-fenced.

Q45 Mr Bradley: That can often be the problem, that money is taken away from alcohol services.
Dr Reid: Yes, it can. I accept it is a problem, but it is no more of a problem than it is in any other area because of (with a number of exceptions, which are national targets) the vast amount of expenditure we are putting into the health service and, as you know, a fortnight ago I mentioned £135 billion and about one and a ½% of that I think is public health additional. With very few exceptions, because we are trying to get more local autonomy in decision-making, they are not ring-fenced, but we hope that

it will be spent and the amount that is intended to be spent and given down is about £95 million, Mr Bradley.

Miss Johnson: There is another point on this, which is where a lot of people have drug and drink problems, and those people are currently receiving a lot of their alcohol treatment services via drug treatment services, who accept that they are going to have people with the dual problem and therefore you need to treat both sides of it. So there are quite a lot of people and some ring-fencing may not be helpful because we may need to continue to develop services which deal with both, although I entirely accept that some of the drink problem needs to be dealt with separately and aside from drugs because it is not related to it; the people are not taking drugs and that is not the issue. But there is quite a large number of people currently in the services who we know are principally getting their treatments as drug addicts but who are also receiving treatment for their alcohol problems at the same time.

Q46 Mr Bradley: Let us go briefly back to smoking then. You seem from previous answers to accept the evidence that passive smoking is dangerous for health?

Dr Reid: Yes. The evidence indicates, and I accept—and it is largely based on living with a smoker—that passive smoking in that situation increases the probability of you ending up with a cancer or other serious disease by, I think the figure is, about 24%.

Q47 Mr Bradley: It is also true that passive smoking is dangerous within the workplace and therefore is not a partial ban on smoking in pubs and other similar establishments dangerous to those workers who have to work in a place where there is not a ban?

Dr Reid: I think the expression "partial ban" while technically correct underestimates what has been done, Mr Bradley. All enclosed public spaces, other than licensed premises, will be completely banned. That means in all work places or unlicensed premises it will be completely banned. In all restaurants, even though licensed, it will be completely banned and in all pubs which prepare and sell food. Our estimate is that it is about 75, 80% of pubs. So in about 97% of workplaces it will in fact be banned. Now, that is partial, I accept, but it is a very big part of 100%, 97, and I think that is an accurate reflection of the total over all. In the three% there will nevertheless be restrictions at the barrier area to minimise any degree of damage from passive smoking. So all workers everywhere will be better off than they are at present and in 97% of areas there will be a complete ban on it. Now, that does not protect everyone completely from carcinogenic elements and smoke, or whatever, and as we were discussing earlier, drink itself is carcinogenic. However, it is by any standards the most major step forward in the protection of the public from passive smoking of any nation of our size anywhere in the world, to my knowledge.

Q48 Mr Bradley: Okay, if we accept the 97% figure, you are not concerned that the three% who are left in a dangerous situation might challenge you, even through the courts, that they are put at risk because they have been left in this (on your figures) tiny minority position of being subject to passive smoking?

Dr Reid: So far as I can make out the figures here, we are talking about the potential number of deaths from passive smoking in the licensed industry—and I will stand corrected by my Deputy Chief Medical Officer here—we are not talking here of thousands of deaths or even hundreds of deaths, we are talking about an estimated something like 40 to 50 deaths at present. If 97% of places and 80% of licensed premises have been reduced, we are talking about the potential of an estimated four or five deaths a year. That is what you are talking about. That estimation would have to be reduced further because we are taking into account the fact that we are protecting the bar area from the effects of passive smoking by the ban, which is the only thing the drinks industry and the bar trade at present are really offering in terms of the staff, and in particular when you consider that there is much more liable, I think, to be a far higher percentage of people in the bar trade who smoke than the residual element of those who will be in that situation. But every single person, whether they smoke or do not smoke, will be in a position where they are far better protected from passive smoking after this legislation goes through than beforehand. There is no question about it.

Q49 Mr Bradley: I just want to come in on the Government's response to the Health Committee Report in 2000: "The government agrees that the health risks of passive smoking are clear. Hundreds of people die every year in the UK as a result of high levels of exposure to passive smoke."

Dr Reid: Yes, and in all those places there will be a ban. That is the point I am making. The only place where there is not going to be a complete ban in terms of workplaces is a small percentage of the licensed trade premises, and the figures I gave were for the licensed trade premises estimates.

Q50 Chairman: Can I just press you on this point? You have used the figure that you could get down to say four deaths a year as a consequence?

Dr Reid: Sorry, estimated. This is all based on estimation, 24%.

Q51 Chairman: We understand that, but the point—

Dr Reid: It is statistically insignificant in terms of any individual person.

Q52 Chairman: The point I will put to you is that death is one part of a range of serious problems that arise through passive smoking. So I think just using death as a measurement is not necessarily a good measurement. There is a whole series of illnesses that people suffer. What I would put to you and what I raised with you—I will bring Dr Adshead in in a minute—when you made the announcement on the White Paper is that while welcoming the step that

you have taken—and I genuinely welcome it; I think it is a very radical step and it is something that many of us have wanted to see for a long time—the practicality of what you are proposing I find difficult to understand. If we can use an example, you are talking about the bar area will be smoke-free in these minority establishments which are non-food but licensed premises. Now, if we talk about a spot that may be known to one or two people around this table, which is the Strangers' Bar in the House of Commons (Mr Bradley knows it), if we had a situation where we had this arrangement there, that the bar area was smoke-free, anybody coming in through the door to the Strangers' Bar would push the smoke forward to the bar area. You are also excluding the fact that if you are in the Strangers' Bar, the staff come out of the bar, in through the side door to collect glasses. The assumption is that their sole area of work is behind that bar. Anybody working in a public house will frequently spend time tidying up ashtrays, tidying up beer glasses, or whatever. Do you not think this is a rather naïve policy?
Dr Reid: No, I do not think it is. If it was naïve, Chairman, I would not have done it. I think it is more sensible than those adopted elsewhere.

Q53 Chairman: It seems to me to be totally impractical. I do not see how you can protect those people from passive smoke in the kind of environment I have just described in the Strangers' Bar in the House of Commons.
Dr Reid: Chairman, theoretically we are bringing in passive smoking in this room. Theoretically, indeed, we are breathing in some of Nelson's last breath because of the distribution of molecules, and so on. So I am not saying that we have got 100% purified atmosphere. I am not saying that. What I said was that every worker will be better placed and better protected after this than before and that in the vast majority of cases there will be a complete absence of smoke other than that smoke which is theoretically there but which results not from people smoking in the area but from the atmosphere, and in those cases where smoke is allowed by choice (because some of these pubs and clubs may choose not to be smoking, remember; we are not compelling them to be smoking pubs) we are saying that in roughly 20% of pubs and in membership clubs (that is not clubs where you can walk in off the street but where members can genuinely make the rules of the clubs) in those areas they may make their own decisions and in those areas where they do they will not be able to say that there will be no protection for bar staff. Even in those cases, which is about 3% of total workplaces, people will be able to have a degree of protection, that is all I have said, around the bar area. I have to say there are two other points which have to be taken into account here. The first is that when you constitute something like 95% of the licensed trade as smoke-free there is a degree of choice for workers to go to the smoke-free jobs which just does not exist at present. That is the first thing. We know, of course, that there is liable to be a far higher %age of workers than three% in the licensed trade who themselves smoke. We are trying to persuade them by other means. The second thing we have to take into account comes back to the balance of what people want in protecting their own freedoms and the healthy outcomes that we seek and all of the evidence that I have seen statistically indicates that while people wanted a complete ban in non-licensed workplaces and most people (80-odd%) wanted a ban in restaurants, 80% of people, or thereabouts, did not want a complete ban in pubs. It is not possible to distinguish, in my view, between large pubs which sell food on a restaurant scale and restaurants. So what I distinguished was not what the public wanted, I went further than the public wants, which is a ban in restaurants but not pubs, and have said that we will have a ban in restaurants and all pubs which prepare and sell food. So that is the second element, which is taking into account what the public want rather than just telling them, "We will tell you what you'll get."

Q54 Chairman: You, presumably, have completely gone against the advice from the Chief Medical Officer on this issue?
Dr Reid: I have reached a different decision from my chief adviser on medical affairs, yes, because as you know advisers in this country advise and ministers decide precisely because we have to balance the health outcomes—which I would not dream of disputing with my Deputy Chief Medical Office or Chief Medical Officer in terms of their assessment. That is their job, to tell me the health outcomes. My job, as Secretary of State, is to balance that with my custodianship of the freedom and the democratic society of our people. That is the primary reason why I reached the decision that I reached on that. I have to say to you the legislation is not there to prevent anybody smoking; the legislation is there primarily to protect those who do not smoke because in this country you ought to be entitled to do that which is legal even if it is against our advice and even if it damages your health. So you can climb mountains, you can box, you can go in speed cars, and so on. What you are not entitled to do is to damage someone else's health and that was the purpose of the legislation.

Q55 Chairman: You have used the issue of freedom frequently this afternoon. You have talked about freedom. You had a better education, I think, than I did but there was some philosopher in the 19th century who said, "Your freedom to swing your stick ends where my nose begins,"—
Dr Reid: Absolutely.

Q56 Chairman: —which I think is very interesting in terms of the smoking argument, because whose freedoms are we talking about here?
Dr Reid: I am entirely agreeing with you, Chairman. You are not free to hit somebody else on the nose with a stick or your smoke, which is precisely why I have brought in the legislation because nobody after this legislation is in who wants to be in a smoke-free atmosphere needs to be in anything other than a smoke-free atmosphere. Every restaurant, every

workplace, every enclosed public space and eighty% of public houses will be smoke-free. So the only people who will be going to the 20% are the people who choose to go, in other words the legislation is protecting you. It is saying to you, "If you want to do that which is legal and damage yourself in this country, though we don't like you doing it we will protect your right to do it. But what we will not do is allow you to damage Mr Bradley," and since 75% of people in this country are like Mr Bradley and do not smoke then we are going to change the whole of the environment in the direction of the seventy-5%. So 80% of pubs, 100% of restaurants, 100% of enclosed public spaces, 100% of workplaces other than licensed premises are going to be protecting Mr Bradley and those who do not smoke. Now, if you want to exercise your legal right to damage yourself against our advice there will be a facility for doing it, and incidentally it means that you do not have to go home and damage to a greater extent those who live with you because you cannot smoke outside so you bring drink home. That is the basis of the legislation that we have passed. Then we say, however, we are going to have an intense effort, Mr Hinchliffe, to persuade you not to smoke. So we are going to give you a very high level of taxation on cigarettes. We are going to give you packets which tell you the horrible things in graphic pictures that you are doing to yourself. We are going to give you a helpline if you want to phone it. We are going to give you constant propaganda or information which tells you what you are doing to yourself. We are going to put a lot of money into smoking cessation clinics, we are going to provide them nicotine-free and we are going to make sure that the areas in which you smoke are restricted to three% of the workplaces in this country. Now, that is the twin combination we are doing. What is the effect of it? I do not know. I think at present if you look at the figures after a lull in the nineties we are beginning to have an effect again and we have dropped now from 27%, or whatever, when I became Secretary of State (I am not suggesting it is me) to about 25% now. We hope to get down to 21%, but also to reduce by the same amount (though to a higher level) manual and working-class smoking. I want it right across all classes and I can assure you I am as absolutely committed to reducing the number of smokers in this country as I can possibly do within what I regard as the environment of a democratic society, and I think we will be effective in it.

Q57 Chairman: Dr Adshead wanted to come in briefly.

Dr Adshead: Just to pick up on the Committee's point, the estimation of what the impact of the different types of ban would have on the population is contained in the partial regulatory impact assessment, which we are consulting on at the moment, and as you have highlighted, it covers not only mortality, deaths, but it also looks at NHS expenditure, reduced sickness absence, so a range of factors. You might find that helpful and we can provide that for you.

Q58 Mr Bradley: Just one final comment really on this from me, Chairman. The purpose of the White Paper is always to look at inequalities in health. Will you be mapping the 20% of outlets which will still have smoking in them to match that against potential sort of social, economic areas because there is an argument that you are more likely to have non-food outlet drinking pubs only in poorer areas because that has been the pattern and the economic group do not necessarily match, so that we can see whether there is an inequality impact of not having all establishments smoke-free?

Dr Reid: I do not think you need to map that to prove the point that you make. I would accept the point you make, that you will get in working-class areas more smokers and more pubs which may be smoking because there are more smokers in those areas. I myself belief that with growing affluence—it is the very point made by the Chairman at the beginning and I think by Dr Naysmith and it was the change of social conditions—I ultimately believe that people take themselves out of disadvantage if given the opportunity and a large part of that opportunity cannot be substituted for by prohibition; not only education but social advance. So in many of these areas I would argue, and perhaps I am a minority, that what you need accompanying all of the things we are talking about in terms of prohibitions, persuasions, and so on, is social advance and social affluence. I guess if you tracked the increase of social affluence in a given area with a graph showing the decline of smoking you would get a pretty near correlation because I think there is a causal relationship in it, and the more that people perceive themselves—and this is the point I made and however controversial it was I stand by it—as having other enjoyments and opportunities and pleasures, and so on, the less liable they will be to regard the thing they are doing which effectively kills them as one of the few remaining pleasures. Therefore, I accept what you say but I believe that by setting the target we have set, by putting in the amount of effort, resources and money that we are putting in—and remember that an awful lot of this money that we are putting in in public health has been specifically directed right towards the areas that you are talking about, Mr Bradley—we hope in those areas not only will there be smoking cessation services up at the National Health Service outlets but in the pubs. In places like Hartlepool, for instance, we are already piloting it and people are going into the pubs with smoking cessation services and talking to people, "Have you thought about giving up? Would you like to give up?" So I can assure you that this is not a diminished effort that has been put into this, but it is an effort commensurate as far as we can with people's love in this country of having the freedom to decide their own lives.

Q59 Chairman: Minister, you wanted to come in briefly?

Miss Johnson: I just wanted to say, I think when all of this has been done we must not lose sight of the fact that whilst we would not want to take legislation

to ban people smoking in their own homes, the biggest health risk that will remain on second-hand smoke will undoubtedly be people smoking where there are other family members who do not themselves smoke, particularly children, and I think we should not lose sight of that. We will be continuing to run advertising campaigns alerting parents so that they can minimise that and try and encourage them to give up, but I would hate us to concentrate on those three% of the remaining workplaces when I think the messages about health for families and what steps they can take and the impact on children in the home is probably one of the most serious things that we have still to tackle.

Q60 Dr Taylor: Secretary of State, to expand on your last answer addressing inequalities, you gave us an example of Hartlepool. Can you give us other examples where you are targeting services for the disadvantaged?
Dr Reid: Yes, I can send you a list, Dr Taylor, of 88 what we call spearhead Primary Care Trusts and those 88 will get extra money, but they will also get the money we are putting in faster then everyone else and we will use the pilot. So we are specifically designing the White Paper so that in the sorts of areas Mr Bradley mentions where there would be deprivation, bad diet, higher smoking, and so on, we accompany what we are doing on smoking with a massive effort in those areas which is even greater and more profoundly resourced than it is in every other area. I am glad to supply those 88. I am not sure from memory whether your area is amongst them.

Q61 Dr Taylor: So these are the PCTs which are getting the biggest increases, presumably?
Dr Reid: They are getting the first amounts of money that are going in and they are getting the biggest increases, as you say, through the recent settlement as well.

Q62 Dr Taylor: Despite devolution, are they being instructed or at least pointed to where this extra money has got to go to help the disadvantaged?
Dr Reid: Yes. Nationally I have agreed—and perhaps we should have made this plain—the reduction in smoking, which I doubled originally from three% down to six%, down to 21%, and notwithstanding what Derek Wanless said I think that was a significant move forward. Nationally that is a target that I have agreed. It is a PSA target which I have agreed with the Treasury, and therefore that is a target which we will be imposing upon and monitoring, if you like, the local primary care trust precisely because not everyone exercises their efforts in circumstances which are equal to everyone else (the point I made earlier on) and we will be putting extra resources and resources in first to the sorts of areas with the biggest indices of deprivation.
Miss Johnson: And of course the target, the manual, has got a much steeper objective on reducing smoking amongst manual groups as well, which we need. The local delivery plans in the PCT areas, particularly in the spearhead groups which the Secretary of State has been talking about, the concentration will be on getting those to deliver, focusing on those groups.
Dr Reid: I do not if you are interested in the figure but disaggregated it is about £110 million on anti-smoking, if you like, tobacco campaigns that we will be spending.
Dr Taylor: Thank you.

Q63 Dr Naysmith: I suppose, Mr Reid, that smoking is just a special example of air pollution and maybe we should turn just briefly for a minute to what you might call real air pollution, and by that I mean probably traffic-related, small particle pollution, the ill-effects of which are well-established now but there is no mention of it really in the White Paper. Why do you not say anything about it in the White Paper?
Dr Reid: I think basically because, as we said earlier, Dr Naysmith, we had to put an envelope corner somewhere and I think you can make a good case for saying, yes, it should have been a part of it, but we decided that the edges of the envelope into which we were putting everything would be to limit it to those things where people are making lifestyle choices themselves. With smoking you voluntarily take cigarettes or you do not. You can affect somebody's lifestyle choice, whereas the environment is more external to themselves. So I do not disagree with the point you are making, that that has a very profound effect on public health. In fact, I will defer to the Deputy Chief Medical Officer, but probably a more profound effect on your health than passive smoking, certainly in some towns and cities, I have read. But then every week I read another profoundly distressing and disturbing piece of research. Recently I saw one which said that in Holland the air inside churches built in Holland is three times more dangerous than passive smoking. I do not know who did the research and I do not know what the background was, but living is a very dangerous thing!

Q64 Dr Naysmith: This is true, John, but we are supposed to be aiming for European standards which we have set out that we are going to achieve and all the indications are that the technological improvements in motor vehicles are not enough to enable us to meet these standards. It is something that we really ought to be addressing if we are talking about public health because I think John is right. I think it probably is a much more serious health hazard than passive smoking. I would not be surprised at all if that is right.
Miss Johnson: We are involved in these things. The answer is, it is just without the scope of the White Paper for the reasons we have given, but we are involved with the WHO's work on air quality guidelines for the world, which is a fairly ambitious programme obviously, and also we are looking at the moment at the effects of air pollutants on the cardiovascular system as well. Obviously cardiovascular disease is one of the major killers still and reducing air pollutants is going to play an

important role on that and there will be a report which will come out fairly soon, a major report on that.

Dr Reid: Just let me say very briefly again that we regard this hopefully as a substantial start to the journey, but it is a start to the journey. The Chairman was good enough to make some remarks the other day where he used a useful word, "dialogue", and I will not hide from you the fact that in several areas he showed a particular interest and made particular contributions which caused me to consider whether I should not give a lot more emphasis than perhaps we had originally done to it, and I did so. So now that you have raised this, perhaps in the future we will turn our minds to that if that is the feeling of your Committee.

Q65 Dr Naysmith: Thank you. Can we move on again, having dealt with air pollution in three minutes, to talking about obesity, which is a subject we have all discussed quite a lot recently including the debate in Westminster Hall the other week. There is a lot of evidence of very poor diets amongst many (maybe even most) pre-school children in the United Kingdom, but again you have not set out specific measures to tackle this problem. Why not?

Dr Reid: I think we have, you see. Perhaps we have not been very good at communicating this, but it comes down to several steps. I think the first thing that we need if we are really going to have what people told us they wanted during the consultation, which was informed choice—everywhere we went people said this, "We want to make our own decision, but we do want you to help us make those decisions and at present, whether it is for our own food or for that of our children at home or of children in a school, we have no idea whether this is a healthy diet or not," and that is why I mentioned the food labelling earlier on. Food labelling is the first step towards allowing adults to make their own healthy choices, allowing adults to make decisions about what their children should have, allowing adults to decide whether or not the level of persuasion on television, for instance, for their children on given foodstuffs is more than it ought to be, and allowing adults to decide what should be on sale in schools, for instance. I mention this because there have been reports recently that we are moving away from our commitment to a simplified form of food labelling. I can assure you that is not the case. As I said earlier, it does not matter to me whether it is traffic lights or 1, 2, 3, or A, B, C, or whatever, provided busy mums and dads, busy people nowadays when they go to the supermarket can get a simplified, easy and understandable form of discovering whether the food they are buying is nutritious or not, if we get that labelling system, of course, and I hope we can get it voluntarily. We are trying to get it voluntarily with the industry. That would be my preference and my desire, but I want to make it plain to the Committee that I am also pursuing the European route and I have already discussed this with the new European Commissioner. I am gratified that he has in a sense taken our lead, indeed he is using some of the words I used in introducing the White Paper. So I think that we have started a movement here that we will not move away from and I do not think Europe will.

Q66 Dr Naysmith: That remark is interesting. We went to see him about six months ago and put the idea in his head, but never mind.

Dr Reid: I am more than happy to give the credit for anything that is going to my colleagues in the Health Select Committee, and again we can try and do this jointly because you recognise, as I do, that this is the first step really if you are going to do anything in a mass way about it. What does it allow us to do? It allows adults to make their choices. I have made that point. Let us leave it aside and come to what you are saying, the question you asked, Dr Naysmith. It allows them to decide as their children grow up what sort of balanced diet they can get and put it into practice because when they go to the supermarket they can have a look at the trolley and they can see from the trolley whether or not the range of foods they are buying for themselves and their children is nutritious and balanced. The next thing it allows school governors to do is to decide outside the home what young people should be offered in the various machines, and the next thing it allows us to do is to make a decision about what types of food should be advertised to what extent on television. I think, therefore, that although it may take a long while before we get a complete and comprehensive labelling system in the sense of applying to all processed foods, nevertheless it is the single most important thing we can do in terms of the diet side, the intake side of that equation of intake of energy and exercise expending it.

Q67 Dr Naysmith: That is great. There can be no doubt that that is the right thing to do. Unfortunately, having talked about schools and children, it brings me back to the dietary standards of school meals, which are produced to a higher standard (because they are statutory) in Scotland than they are in England and I wonder what we can do about that. I know it is not directly your Department's responsibility.

Dr Reid: No, it is not, but as you properly pointed out earlier and the Chairman pointed out, so many of these things are cross-departmental and we are trying to deal with it on a wider scale than ever before. I did have long discussions with Charles Clarke on this. I did go and visit a number of schools with him. I have already had discussions with Ruth Kelly on this matter as well, and indeed we share some of the responsibility because with the free fruit scheme which we piloted just when I came in as Secretary of State I then decided, because of the success of that, to extend it to every school in England. It has had some very interesting side-effects because when we introduce, as we are doing, every four, five and six-year-olds to fruit every day—and some of them have never seen some of this fruit before—we are finding out that at the levels of six, seven and eight years of age and nine and ten in the primary school in the tuck shop they are asking for fruit. So we have an input into that. I will ask Fiona

to comment on this, but as I understand it we are looking at an appraisal of the schools, both primary and secondary, in terms of nutrition. That would include observing and taking note of what is happening in Scotland with a view to making decisions here in the DfES. Do you have any further details on that, Fiona?

Dr Adshead: Ruth Kelly obviously announced recently, on 10 February, that they want to take further action on the school meals which went beyond what we said in the White Paper, which has obviously included encouraging parents to take action through a parent tool-kit, setting up and independent school food trust, but also thinking about tougher standards, particularly for processed foods in schools, and we will be continuing to pursue nutrient-based standards for school meals.

Q68 Chairman: Just briefly on the traffic lighting issue, you are probably aware that I raised a concern in the obesity debate the other week at the way in which I understood that there was some attempt being made to specifically target the official from the FSA who had been involved in the excellent work that they did on nutritional profiling, to target him within Europe. We have some anxieties over what will happen here. You have given assurances today that you are firmly committee to some form of traffic lighting system along the lines we suggested, but are you conscious of the efforts that are being made to undermine that direction of travel and will you resist those efforts?

Dr Reid: I am pausing because the one thing I have never been accused of being in my life—and I have been accused of many things—is diplomatic, so I am just trying to find the words! I have found in changing things that very often there is an intrinsic vested interest in the status quo, and I understand that. Having changed the National Health Service, this morning I was defending some of the things we were doing. These things are controversial and I understand people have an interest in it and my inclination, Chairman, is always to try and do things with partnership. That is what I want to do. I want to do it voluntarily in partnership, and indeed in the first half of this I have perhaps been under critical questioning because I took the same views regarding diet, smoking, and so on, that voluntarism is always better. However, when Parliament has decided on something, Parliament has decided and I would not want anybody to think that we were going to be deflected from this. It is an integral part, in my view, of a public health-wide policy. I want to get it voluntarily. We would have to get it voluntarily if it is at a UK level. It is the best way of doing it. But I believe there is a great deal of support out there in the country for this and I believe the best thing the industry can do here is engage with us in doing this and engage with the FSA in it. I have no evidence of pressure being brought on any of my officials on this. Any discussions we have had with the industry have been fraternal, they have been frank, and so on, but all I can say to you is, with as much delicacy as I can, that we will make sure that what has been passed by Parliament and decided will be implemented.

Chairman: One or two of us learned some interesting lessons on the publication of our obesity report. I will not go into any more detail, but the Minister is fully aware of what I am talking about. John.

Q69 Mr Jones: Secretary of State, whilst Doug Naysmith was, I think, comparing the nutritional standards in Scotland it reminded me—and I am delighted to see that Ruth Kelly is now beginning to move in this direction—that I think the TV chef Jamie Oliver compared the nutritional standards of food served I think in a South African school in Lesotho with food standards in British schools and whilst every other standard of investment, of course, in Lesotho was vastly inferior the food that they served in the South African school was superior to ours because they served real food. I entirely agree with the thrust of the Government's policies and your own personal policies on choice, but giving children free choice in what they should eat is a stupid thing for any parent to do and it is a stupid thing for the state to do as well.

Dr Reid: Can I just put on record I agree with you entirely. I have always spoken about adults having informed choice but the one area where I did say at the beginning people wanted information, resources and protection—and I said from the irresponsible behaviour, as they see it, of other people—that was a reference to passive smoking, and we have moved on that. They want protection in particular for children. That is not just something which lies within the ambit of the state, it lies with parents, but parents expect the state to give them a degree of support and I completely reject any accusations that were made, and some of them were made in some of the tabloid press for their own reasons, that this White Paper was in any way nanny state-ish. It was not, except for children, and that is what nannies do, is it not? They protect children and the role of the state is to help parents to protect and develop the children. I agree entirely with that.

Q70 Dr Taylor: Going back to informed choice, one of the commitments in the White Paper is: "We will also commission production of a weight loss guide to set out what is known about regimes for losing weight." How far have you got with that? Who is writing it? Who is being consulted on it?

Dr Adshead: We are essentially beginning to think about how we do that and obviously at the moment NICE is looking over all of the obesity guidelines and so we are going to be working with a number of professionals to do that. We have not got too far down the line on that. That is something we feel we need to do because I think, as you are suggesting, it is very important that we give individual members of the public as best we can evidence-based guidance on what diets they themselves should adopt should they wish to lose weight.

Q71 Dr Taylor: But we can be reassured you will do that as quickly as possible and not wait for NICE?

Dr Adshead: No, we are doing that as quickly as possible, but we need to work with NICE on this.

Miss Johnson: We are writing and coming to the end of the process of writing the delivery plan for the White Paper and also the food and health action plan and the physical activity plans which we hope to publish at the same time soon. The result of that will be that all the areas where we have made commitments will have more specifics against them about the way in which those are going to be delivered and by when, and so forth. So you will be able to check us out on that and on other issues before too much longer in more detail.

Q72 Dr Taylor: Thank you. Turning to the cost of food and convenience foods, there seems to be quite an explosion of fast food outlets in town centres. I am going to be tarred again with the brush of increasing taxation here, but would there be any scope for licensing or restricting the number of fast food outlets, and do you think that would have any effect on public health?
Miss Johnson: I do think there is a mixture here between serving a market and what the market wants. It is very interesting, just going back to the school fruit, if I may, because I have seen myself children eating fruit which even I, as a parent who fed my children quite a lot of fresh fruit and vegetables, would not have thought children would eat. If you create a demand for raw, sugar snacks cut in two and that is what they would like to eat then my guess is that the market will do much more to try and meet those needs. Now, it is two-sided because we have to change the market at the same time, but I think the idea that we only work on either one end or the other end of that problem in isolation would be to restrict ourselves and to make change very, very difficult. I am not signed up to your manifesto yet!

Q73 Dr Taylor: We were very encouraged during the obesity inquiry to hear that some of the fast food outlets were working out how to give fruit and salad as well.
Dr Reid: It is very interesting and quite encouraging, and I hope it is not something that was only happening during the consultation period in order to avert something more stringent being put in, but you may say hope springs eternal. I hope it was not and that is why, I think, I am sending out the message to anybody who wants to listen on this that we intend that this will happen. Work with us to make it happen. I think there is a legitimate fear, and this brings us back to the food labelling. Some people say to me, "Look, you can't have a 1, 2, 3 or a red, green, whatever, because you're saying some foods are bad." No, we are not saying that. If foods are bad, they should not be on the market at all. What we are saying is we need a way of telling mums and dads who are quite busy but more than ever now are interested in their diet which foods they can eat endless amounts of and still be quite healthy, which need to be part of a balanced diet and which need to be eaten very sparingly. Now, some of the very "sparingly" foods can be very good and nutritious foods. So we have got to work out a system which does not condemn any food which is on the market because the food which is on the market by definition would not be on the market if it was food which does damage to you.

Q74 Dr Naysmith: Is it possible, Secretary of State, to have a food which does not do any good at all of any sort other than satisfy the need to stuff something in your mouth?
Dr Reid: I have always regarded lettuce as a bit like that!

Q75 Dr Naysmith: No, no, no, that is not true.
Dr Reid: I know. My Minister keeps telling me it is not true. I've always thought lettuce was the most expensive possible way to pack water as far as I could see!
Dr Naysmith: I was thinking of Pot Noodles actually.

Q76 Chairman: Do not mention Pot Noodles!
Dr Reid: No. In a desperate attempt to persuade the press that I was only joking earlier on, I had better say—and I only mentioned lettuce because I eat endless amounts of it—I have never in my life had a Pot Noodle, I can say. Dr Naysmith, you can tell us. In any case, I think at the moment with Sudan 1 we have a problem in that direction anyway.

Q77 John Austin: You will recall in our report we looked at issues such as cycling and walking when we did the obesity inquiry and identified that the UK was somewhat behind some of our European partners. I very much welcome the Government's commitment to create a better environment for walking and cycling, but in your White Paper you have urged highway authorities in developing their local transport plan to involve NHS bodies, particularly Primary Care Trusts. I tend to think that walking and cycling might not be very high on the agenda of most Primary Care Trusts given the plethora of difficulties they face. Could I ask what evidence there is that PCTs are becoming involved in developing local plans and what your Department can do to encourage that?
Dr Reid: Actually, I think you had some scepticism about PCTs being interested in local planning, and so on and so forth, for roads. The people who are interested are both local public officials and local authorities, especially the scrutiny committees, local authorities, and remember they will have a scrutiny function which runs across a number of health things but including public health. So I would hope that the impetus given by the White Paper and the discussions and the awareness now means that people in the local authority would be asking this question and perhaps drawing in, as it were, the local Primary Care Trusts. I know we are all biased on this, but one of the best things which could happen in terms of encouraging sport in this country is to get the Olympics, and I have to say that I have mentioned several Secretaries of State earlier on, and not just for London, Chairman—

Q78 John Austin: It is all right, the person who asked the question agrees with you!

Dr Reid: One of the reasons, Chairman, is that if we won the Olympics in London this time it surely would enhance the chances of getting it at Manchester the next time, and I am sure we will get you on the committee on that! I was going to say that I think the Secretary of State for the Department for Culture, Media and Sport has been, not only in the Olympics but let me tell you has been deeply involved, encouraging and supportive of everything we have done in the White Paper. Of course, she wrote the first White Paper under this Government on health, but she has been strongly supportive of it.

Q79 John Austin: I want to come on to sport in a moment, but if we can stick with walking and cycling at the moment, the White Paper talks about the advantages of walking and cycling but is a bit short on suggestions on measures to promote this. Has the Department given any further thought to the promotion of walking and cycling?
Miss Johnson: Yes, and obviously I mentioned the physical activity plan and the delivery plan for the White Paper. There will be a lot more detail about taking forward all these strands of work in that, but what we have also said is that we want all schools, for example, to have active travel plans by 2010. Just going back to the earlier discussion—

Q80 John Austin: Why 2010? 2010 seems a long way off.
Miss Johnson: That is all by 2010. I have many schools in my constituencies that already have them. I am sure other Members likewise have a lot of schools that already have them. The question is just making the progress through to the end of that. There are issues for some schools in the routes that children would have to walk and getting volunteers and getting things set up. It is not all straightforward in all environments. But just to go back to the earlier point about air quality, and so forth, and hazards on the road, all of these things contribute much more to things like accident reduction ultimately and a healthier environment as well as people themselves being healthier, and in a lot of cases it will encourage more adults to walk. In one of the examples I saw in the country where they had encouraged children to walk to school they had done it by clearing drug needles out of an area, making the path much better, a direct path and having some adults along it, which other than helping young children going to school to walk in that environment was creating a much better environment in that community. Going back to the point the Secretary of State was making earlier about the involvement of the local authorities, we do think that it is absolutely crucial to the delivery of the White Paper and I think throughout much of this you have not perhaps been questioning as much as anything that we need to get it delivered.

Q81 Chairman: That is the next session!
Miss Johnson: But let me tell you, Chairman, we are very fixated on the fact that we have to get this delivered because we do not want it to be just another White Paper on public health. We want things to happen and it is the partnerships, for example, with the local authority on things like walking and cycling which are going to be absolutely crucial to making that particular strand and a number of others happen on the ground. It is not only the health service and it is not only public health.

Q82 John Austin: I welcome the development of safer cycling routes to school and the links with the cycling network, and it is specifically mentioned in the White Paper. The amount of money put forward by the Department for Transport, however, was a one-off and it is not a rolling programme, so I wonder if the Department of Health might have some influence with the Department for Transport to ensure that it is a rolling programme of the expansion of links to the national cycle routes?
Miss Johnson: We are obviously working closely with them. One of the other things is on cycling proficiency, where we are determined to get cycling proficiency training in again. Many of us learned to ride a bicycle and then were given proficiency training as young people. That has tended to go out of circulation. We want that to be available to young people across the board again and we are looking at ways to make that happen and working closely with the Department for Transport on things like that.
Dr Reid: Just one comment from Fiona.
Dr Adshead: I think in terms of encouraging PCTs to engage in active travel, we are working with and have funded Sustrans to work with the NHS to develop green travel plans so that we hope that that will promote the kind of action that you were suggesting.

Q83 John Austin: I know that targets are touchy issues, but I note that the Department for Transport has abandoned its targets for increasing cycling levels. Perhaps that is something you might enter into some discussion with them on?
Dr Reid: Yes. I think I may have introduced that target as Minister for Transport! I am deeply offended if that is the case. I am moving so fast, you know, there is every chance I could end up there again! Thank you for letting me know.

Q84 John Austin: Can I take you to safer areas and come back to the promotion of sport and physical activity. I think we all acknowledge that there has been an unprecedented investment in sport in schools in recent years, but the target which is talked about in the White Paper is the two hours per week of physical education or sport. Are you satisfied that that is within the curriculum time? Are you satisfied that that is enough, and is that going to be real physical activity rather than talk about physical education?
Miss Johnson: All the evidence, interestingly, is that aside from English, maths and science the next biggest chunk of the curriculum given over to any subject is to PE, which is good. You are right, obviously we do have the two hour target. We also have, as the Prime Minister unveiled, half a billion pound boost for PE and sport in schools in December of last year. He announced at the same

time that we would have even beyond that four hours of high-quality PE and school sport each week by the end of the decade as a target. Now, some of that is within the curriculum time of schools, within the taught time, but some of it is obviously outside of those. It is by extending school, it is by doing things at weekends and at other times, but that would provide an even wider number of hours with very active children. I also say, as for adults what we need to do is to increase the way in which exercise is embedded naturally into children's lives, as it should be for adults. So more walking, more cycling of an every day kind as well, more of a general physical activity around. I am worried about the Chairman's retirement on to his sofa in front of his television and I think his pedometer will serve him well in the future, because I think that what we do not want to do is to have people generally with sedentary lifestyles, and that includes young people. So I think that whilst sport is enormously important and we are putting huge investment in it, we are not saying all our eggs are in that single basket either.

Dr Reid: Very briefly, I managed to discuss a number of things, including nutrition in schools, with the new Secretary of State for Education. I have not discussed this, but I know from the general discussions about her philosophy of education and her own background and commitment, which to some extent I think was displayed today when she talked about the basics, that she does believe in an ethos of the whole person and I would not be at all surprised if sport and physical activity was a very important part of her view of a healthy developing young child along with English, maths and the other things she was speaking about today.

Q85 John Austin: Perhaps you might also talk to her about how schools might develop more out of hours school sport as well and how those facilities might be developed?

Miss Johnson: The extended school, obviously, and the children centres as well offer opportunities for extending the range of what is being done both within school and outside of school.

Q86 John Austin: The other issue which has arisen is that surprisingly, I think, it came to us that there is a lack of physical activity often with pre-school children. I wonder what the Department is doing to encourage more physical activity for pre-school children?

Miss Johnson: The Sure Start schemes obviously look particularly at all aspects of young children's health, particularly families who are involved with Sure Start, which we have got very extensive Sure Starts and the children centres will be taking quite a lot of that in, as it were, and developing it. I saw myself in Devon just a few weeks ago at a healthy living centre young children coming in for help with physical skills who needed more physical skill development and were coming in for a structured programme with parents or helpers to help them develop the skills at a very young age, tots two, three years old, who need additional help. So there is a range of programmes for those with particular needs through to those who just have a more general but important need. I agree with you. I think it is very important that they start young, but all the evidence also is that we need to get it right right across the primary schools because if by the time they go to secondary schools they do not have the skills to participate in sport and a general physical fitness then very rapidly they drop out or cease to be really engaged in the things which are going to give them long-term well-being.

Dr Reid: We have been working on a physical activity plan, which is due out next month, and the importance of play in that healthy development. You may be interested to know, I do not think the Minister mentioned, just briefly, there is a lot of money being spent on this including the Lottery money. I think the Government is investing something like £1.5 billion in sport and PE over the 2003 to 2008 period. Sport England last week announced, I am told here, £350 million funding for sport.

Q87 Chairman: Good. I know that one or two of my colleagues want to come in on this issue before we go on to delivery, which Richard will lead on in a moment, but when we did the obesity inquiry some of us spent some time at Bradford Bowls Rugby League Club looking at what they were doing on health issues with local schools and we were very impressed by the connection between professional sport and health education. I am conscious of some frustration among a range of sports. I think there is a huge willingness to get involved in the health agenda but a feeling that in a way they cannot seem to get access to where they can work with PCTs or the Department. One example that I would certainly ask you to look at is where I attended a meeting in the House of Commons a couple of weeks ago, a unique meeting which drew together both codes of rugby, which have not had the greatest relationship for 105 years, but working together on a proposal for what is called a 30 minute squad where they have got a series of professional players willing to go into schools as role models and work with youngsters, but they are finding difficulty in establishing a way into the system to do that. I know that they have talked to somebody who has been very helpful in the Department, but I think the sort of way in will be at PCT level. But it is very difficult for them to know how to do that without the blessing of the Departments at a national level. I do not think it is just the two codes of rugby, I think it is other sports as well that have a lot to offer and genuinely there is a willingness to move it forward.

Dr Reid: We are completely at one on this, Chairman. Right from the beginning of the consultation and my beginning as Secretary of State for Health I believed that on this issue we needed to think out of the box because I used to say that people from the area I come from, and certainly yours, are not deeply impressed by people called Sir Nigel Crisp or Sir Liam Donaldson, Chief Medical Officer, telling them how to live their lives, or me, some Cabinet Minister telling them how to live their lives. However, if the local football manager or the local

rugby club decides that they are going to get involved in something at a school level upwards, the rugby club and the football manager, and so on, will have a far greater effect. So we have been trying to do this and you are right, there is a problem here because if you are decentralising power to the locality how do we steer this from the centre by engaging with people like rugby clubs, and so on. Fiona has been working with this. We are working closely with the Department for Culture, Media and Sport, Sport England and the professional bodies such as the football clubs, the Football Association, the Premier League and also Premiership Rugby on this. But I think what we have got to try and do from the centre is two things. One is to make the information available to the primary care trust and encourage them to do so. So you make the information available. We are now doing that, are we not?

Dr Adshead: Yes.

Dr Reid: We are saying to them at the primary care level, "Get in touch with your local rugby club, football club, and so on, and identifying the contacts and all the rest of it," but the second is in order to encourage them rather than just informing them to do that we are now holding a series of regional seminars for PCTs and sports clubs. So that is trying to combine our role at the centre with devolved decision-making. It will still ultimately be up to the primary care trust. Your view, and presumably that of your Committee which you have just expressed, is entirely in accord with us. I cannot say how supportive we are of what you are saying. It is not being delivered on the ground yet and we want it to be, and we want to cut through the bureaucratic fog which sometimes prevents this from happening.

Chairman: That is helpful.

Q88 Mr Jones: Secretary of State, on Monday I was with two of my constituents and their family, Mr and Mrs Underwood, outside a swimming pool with their two eighteen-month-old twins and their three-year-old and we were prevented from going into the swimming pool. There will be another four years before the two parents are able to take the three children into the swimming pool and there will be another six years before any one parent could take the three children into the swimming pool. Could you ask the Secretary of State for Education, who I am sure is well aware of the problems of having young children, that this is an absolute madness and to somehow allow local authorities to act responsibly rather than just be defensive and ensure that there is no chance in a million they can ever get sued but on the other hand no young children will ever learn to swim?

Dr Reid: I will both raise this with the Secretary of State for Education, who as you say at this rate it may be several decades before she can take all her children to the swimming pool, and with the Department for Culture, Media and Sport because I think they have the responsibility for that coverage. I am afraid I only have read about this, I do not know it in detail, but I accept the description you give of the problems that will be faced and I will certainly raise it with both of them.

Q89 Mr Amess: Before we get on to the final section of delivery, which I have certainly got a few points I wish to raise on, I want to ask two or three questions about mental health. I would like to know why is the nation's mental health given such a low priority in this White Paper? I think we turn to page one hundred and thirty-one before it is mentioned, section 37, where we are told: "Transforming the NHS from a sickness to a health service is not just a matter of promoting physical health. Understanding how everyone in the NHS can promote mental wellbeing is equally important—and is as much of a cultural shift." This should have been said at the start of this White Paper, not left to page one hundred and thirty-one.

Dr Reid: The reason is precisely because we thought it was as important as you are making it out to be that we decided not to incorporate all of it inside the White Paper but to have a section in the White Paper which referred to it and simultaneously to develop and publish, which we have now done, in the immediate aftermath of the White Paper a full national service framework on mental health, which is the first time that has ever been done. So I am the first to accept, Mr Amess, that mental health has been up until very recently the Cinderella in terms of health, but I assure you that the reason why there was, if you like, a summation towards the end of the White Paper was because it was about the only subject in the White Paper where we were doing a separate, more detailed and more directive section of the national service framework outside of the White Paper so that there is a cross-reference.

Q90 Mr Amess: Two questions following from that. I think at the start of the afternoon we talked about health trainers. What skills will these health trainers have in dealing with people who have mental health problems, or are they going to be left out of this equation?

Dr Adshead: The principle of health trainers is that they will be trained in health psychology techniques. So they will really understand what makes people tick and they will really understand their motivation. One of the points we make in the White Paper, and maybe we could have been more explicit, is that in order to make any healthy choice you need to have a certain level of confidence and a certain level of emotional wellbeing. So understanding people's motivation and building that kind of confidence will be key to the role of health trainers, and we do have a number of commitments in the White Paper around emotional wellbeing linked to Sure Start, the importance of it in healthy schools programme, very much building that kind of confidence and life skills as children grow up. So it is core to the White Paper but I think you are right, we might have done more to bring that out and make it more explicit.

Dr Reid: It is one of the six key priority areas.
Miss Johnson: You and the Committee have been talking for some time about aspects of mental wellbeing in terms of thinking about what enables people to change their lifestyles just like the issues about people's ability, if they are in poor circumstances, to look after and change their own health. A lot of that is about their mental wellbeing, and interestingly on your earlier point about the sports clubs, when I saw what Middlesbrough, for example, as one of the premier clubs who are doing things of the sort that you are talking about now are doing, one of the things they are doing is building self-esteem and self-confidence in the work that they are doing with both young men and young women from their own community in doing the sorts of programmes that they are doing which looks like physical activity but is much more subtle beneath that, and I think the connections are very important and you are quite right to emphasise them.

Q91 Mr Amess: I am really pleased to hear this anyway. That is good.
Miss Johnson: We accept entirely that those connections have got to be made and built.

Q92 Mr Amess: Okay. Excellent. The final point I wanted to ask is what measures will be used to assess improved mental health within the 88 Primary Care Trusts which have been chosen to be the first to get funding? Have you got any information you could give the Committee about that?
Dr Reid: The spearhead. Do you mean in advance or in addition to—

Q93 Mr Amess: What measures will be used to show the improvement?
Miss Johnson: First of all, all the PCTs including those who are covered in the spearhead, the eighty-eight in the spearhead group, will have to produce local delivery plans. There are some core areas where they have to produce what their plan is to contribute to things like, for example, reducing child obesity and various other strands like smoking, including pregnancy. Then they can add other areas on to that. We will be checking their delivery against those plans. The Strategic Health Authorities will be doing that on our behalf. They will be supporting and monitoring that delivery. One of the things we will be doing is that and at regional level we will be producing six monthly reports on progress, which is the aim, as well. So there will be a whole variety of measurements going on and checking that we are making progress on things across the board, and that will cover this area as well as many others.
Mr Amess: Okay. We are on to delivery then inadvertently.
Chairman: I am conscious that we have kept you two and a half hours. We hope to conclude fairly soon, but before we do perhaps some shortish questions on delivery, Richard.

Q94 Dr Taylor: Delivery. I am sure we are all very encouraged to hear that you are determined to see the White Paper delivered. One thing which slightly bothers us is, I think you are going to give six month progress reports on the implementation but we are very worried about whether you are going to have the up to date information to do that because if we look at the information you have got about smoking levels these are about two years old. How are you going to be sure you have go the up to date information to be able to tell us that you really are achieving?
Dr Reid: First of all, in terms of monitoring delivery we will have local targets, as I think Melanie has just said, in a whole series of areas, one of which is smoking. So at the locality they will be monitoring these and we will have to monitor them to see that they are delivering them. In addition to the local targets, which are core targets incidentally, there will be some others because the PCTs can choose them and the performance levels within these targets (particularly the core ones) will have to be agreed between us and we are in the process of discussing these things now. So there will be a system whereby there is an allocated target on that and where it will be monitored. In the spearhead PCTs, which is the area Mr Amess was asking about, the Strategic Health Authorities there will ensure that they are making faster progress than the average primary care trust in these areas because they are getting more money by and large and they are getting money earlier by and large because they have got greater problems. So there will be a degree of monitoring which is not there. I think this has already proved effective in some areas and the one example I would give, and it is what I said at the beginning, I do not agree with everything that Derek Wanless has said any more than he agrees with everything I have done, but if you look at the smoking cessation services we have something like now eight hundred thousand four week quitters through the NHS stop smoking services target and that has worked to motivate the NHS to deliver. They have seen that they can work this, and they have seen it can work because we were prompted to start looking at the figures because people like Derek Wanless were saying, "You don't have the evidence for this. This is an expenditure and I don't want to waste any money." So we started to look at it and you will see there are eight hundred thousand. So I can tell you that some three hundred and thirteen thousand people since April 2003, which is just before I came in because I wanted to know how many people stopped through smoking cessation services roughly since I came in and from the financial year starting in 2003 three hundred and thirteen thousand people have quit smoking with the smoking cessation services. So we are now, Dr Taylor, beginning to monitor it so that we can be reasonably sure that in most of the areas we will have a pretty good guide as to whether we are delivering or not.

Q95 Dr Taylor: When you have made the plans for monitoring would we be able to know the details of the sorts of things you are going to monitor so that we know how to follow?

Dr Reid: Yes. I do not see any problem with that at all. There are four main areas. We have got improvement in the health of the population as a whole. So let us agree how we are going to measure that. Now, we have got a problem there with the Office of National Statistics because—

Q96 Chairman: Do not get him going on that one, please!

Dr Reid: Right, but at least we can work on a rough assumption that if you die we have not succeeded and that if you live there is a quality element here that ought to be taken into account. So you have got the health outcomes of the nation as a whole, who is smoking, who is not smoking, and so on. Then you get improvements in the level of quality of service delivery. That is data submitted by the Strategic Health Authorities, and so on, for instance, to measure the forty hour waiting time target for sexual health access. Then you have got the reports on the delivery of publicised project milestones and trajectory, in other words the ones where we say, "Here are the milestones we want to hit." Then you have got inspections carried out by the Healthcare Commission that we have established and others. So there are at least four major ways of measuring and we intend to do this through six monthly reports and we are more than happy, given the partnership we have had with the Select Committee in fashioning this, to share with you our information as we go on.

Dr Adshead: Our technical guidance note that goes out as part of our primary care trust details the specific monitoring lines they will be asked to look at, for example measuring body mass index in the adult population, and this week, on Monday, we supplied them with the planning tool-kit which gives them a bit more advice and a bit more support on how they might go about doing that and what is best practice, what we are calling the sort of "big wins" would be to ensure local delivery.

Q97 Dr Taylor: Did you say that has gone out?

Dr Adshead: The technical note went out in the autumn, around November, but the tool-kit, which gives the more detailed information, went out this Monday.

Q98 Dr Taylor: Are they being instructed to weigh and measure children at school?

Dr Adshead: We are working with the Department for Education and Skills on that.

Dr Reid: We are having a discussion with the Department for Education about that matter.

Miss Johnson: Implementing it.

Q99 Chairman: Can you be a bit more specific about the issues around that because it was something that I think we were surprised about?

Dr Reid: About skills? Yes. The one thing that Charles Clarke and I agreed on was that we needed to put health more at the centre of what is happening in skills. That had a number of dimensions. One was to make sure, just in the same way that I believe better off people could get access to advice and personal trainers then we should give something of that nature to people who were not so well off because we assumed it was a good thing. So we believe that if in schools where people pay for their kids to go to the central role is played by the school nurse, there should be at least one school nurse for every cluster of schools. That was the next thing. Then there was nutrition at school, which we are dealing with as well. The other thing, which was slightly more problematic, was to decide what we could agree on in the monitoring of the development physically of a child at school. I think it is fair to say there are different views on how you should do this. My old-fashioned instinctive way of doing it was to say you measure people, their height and their weight and look at their arms, and so on, every so often, but people who are much better educated than myself in medical techniques told me that this was an unproductive use. I am not looking at Fiona because she was the one who told me, but others who have said that this was not the most productive way to do things. So we came to a sort of compromise at this stage and we are continuing the discussion. Would you like to just tell us about it, because I think the Committee would be interested.

Dr Adshead: We do have national monitoring information, as you are probably aware, through the health survey for England so we know the proportion of children who are, for example, overweight. We have information on average weights for children at different ages. We are in active discussions with the Department for Education and Skills. There may well be a mechanism for school nurses to measure obesity One of the things we need to make sure, though, is that when we are measuring school children we need to do that sensitively so that we do not stigmatise them, we do not make them feel miserable because somebody has told them that they are overweight. So we are taking it very seriously because we absolutely do need to know the extent of the problem, but we are trying to do this in the best way, putting children's best efforts at the heart of how we are approaching this.

Dr Reid: So what looked to me like the simple solution, you see—and this is where Mr Amess's point comes in—is not always the simple solution because you have to see the whole child and the psychological effects, and so on, of it. So we are continuing discussions about how we might do that.

Q100 Chairman: I think we understood the sensitivities and appreciate exactly the point that Dr Adshead has made, but we felt that this problem ought to have been looked at probably more keenly than it has up to the present and that there should have been some connection to advising parents on what could be done to assist their own children. So we are grateful that there is some continuity.

Miss Johnson: I think we fully agree with the Committee about this.

Dr Reid: We accept that.

Miss Johnson: The evidence is that a lot of parents do not understand that their children are significantly overweight or obese and the connection certainly needs to be made there, but there are all

sorts of questions about the use of, for example, the people in schools, the school nurses in the clusters and how their time is used best and support into the community with parents as well as with the children in schools.

Q101 Dr Taylor: You have told us about these tool-kits for PCTs. Are you quite confident that they have got the time and the expertise to implement these tool-kits?
Dr Adshead: Essentially, we are going to be working very closely with Strategic Health Authorities to ensure that we give the right performance management and assessment, and one of the things that we say in the tool-kit is that we are looking at how we might, just as we have done for waiting lists, look at a national support team for some of the key areas, for example smoking, sexual health and obesity, to work locally on the ground because it has worked very well, for example, for orthopaedics. So we are thinking how we can apply some of the tools and mechanisms that have been so successful for NHS services and apply these to public health to really give people the support on the ground if they are finding it difficult to implement some of these changes.

Q102 Dr Taylor: So you would send a team into a PCT to help it?
Dr Adshead: We are looking at how we might best do that and we want to learn from what we have done with hospital services, for example around orthopaedics. We have not come to a conclusion at the moment as to how it is best to do that.

Q103 John Austin: I think you may have answered one of my questions. My initial reaction to the delivery plan was that it was somewhat vague and a set of things and aspirations rather than a delivery plan. It may be that the tool-kits and you circular to the PCTs may have put the sort of meat on the bones of that and it might be useful if we could see that. That may well overcome our concerns.
Miss Johnson: It will be published but it does go through all the one hundred and seventy areas. Obviously some of those are much more important and some of them will take longer to do than others, but it does go through all of them as well as setting out areas where we can make big progress.
Dr Reid: I do not intend that this should be a White Paper full of hot air that never gets anywhere. The purpose of coming into government is to change things and when I have been left in a department long enough to do it I have tried to change things. I reconfigured the Army under the Strategic Defence Review, delivered the Scottish Parliament with Donald Dewar and did various other things in Northern Ireland at decommissioning, and this is one of the big things that I want to do in health, which is to take this through. Now, where we are on this is you start off with the grand design, if you like, the strategic purpose, which is a White Paper. We are now converting that into, if you like, an operational plan, which you still thought was not specific enough and I agreed with you because it was the general outlines of the operational plan to implement the grand strategy. But what we are doing at the moment is we have got a planning and performance tool-kit which has just been mentioned there, but we are also in consultations with the Healthcare Commission at the moment about how we translate the standards for assessing health improvement. We are in consulting with the Office of the Deputy Prime Minister in assessing local authority performance and delivering improved health care. By May of this year the Primary Care Trusts will have agreed local targets to turn those aspirations into action on reducing adult smoking, increasing the uptake in breast feeding, tackling childhood obesity, reducing under-18 pregnancy, improving mental health (the point that Mr Amess made), better management of blood pressure and cholesterol, and indeed next month we will have a delivery plan for choosing health which will be published, which will have a strong emphasis on ensuring delivery on the ground, the very thing that you are talking about. So it does take a bit of time but it is not stopping; it is going to go on right into delivery.

Q104 John Austin: We talked about your relationship with other departments earlier on. Some of the written memoranda that have come to us do not believe that some departments take public health as seriously as we might like them to. Could I ask you how many times the Cabinet Committee on Public Health has met since it was set up?
Dr Reid: I think it met three times, but I would not want you to think that was the area where the discussions took place. That is where you would have what you call three second readings, discussions and debates. There is a massive amount of work done bilaterally by officials. There was a great deal of work done bilaterally by ministers and there is some work (only some, as you would expect) done bilaterally by Secretaries of State. But I met Tessa Jowell several times, I cannot remember how many times, probably five, six, seven times, specifically on this. I met Charles Clarke, four, five, six times on it, and so on. So there was quite a lot. There is the MISC 27 on top of that, so that when there was anything we could not fix or we wanted the general strategy agreed we did it at MISC 27. Then we have got joint targets between departments, which is a separate thing, which does not operate through MISC 27 but operates through the various PSA targets and the Chancellor, and so on, and the Treasury targets there. Then we have got joint Government arrangements, which require other meetings in a different forum from MISC 27. Then we have got the wider actions on the social problems that you are talking about elsewhere. I only list them, Mr Austin, just to indicate MISC 27—when I say three times I understand that will look as though, well, is that the only thing that happened? There was quite a lot. Where perhaps we are not so strong and perhaps we should look at is—that was fine up to the publication. Okay, let us have a look at the delivery mechanisms now, and perhaps we could send you a

note because I know you are a bit short of time on how we are carrying on inter-governmental delivery, if you like, beyond MISC 27.
Chairman: That would be helpful.

Q105 Mr Bradley: Could you include the role of the Strategic Health Authorities in that monitoring process and their capacity to undertake that task—because I know from Greater Manchester that they have a huge number of PCTs which they are coordinating—to have this monitoring role of these activities in public health? Have they got the expertise and the capacity to undertake it?
Dr Reid: We will do that, but remember it is not the only one because you have got the regional directors of public health and they are public health groups, and you have also got the government offices in the regions. So I am not suggesting that they are the major movers but there are several bodies there which could be involved in this.

Q106 John Austin: The White Paper places great emphasis on encouraging and enabling people to make healthy choices and I think we would all welcome that as something highly desirable, although there is some evidence to suggest that appeals to individual behaviour will have only a modest public health impact. The major advances in public health have come about from government action, often through regulation, sometimes through taxation. Do you accept that the primary responsibility for improving public health lies with the government and not with individuals?
Dr Reid: No, I am sorry, the timely responsibility for improving your health lies with you and the whole of history teaches me that in the relationship between the collective (i.e. the state) and the individual it is the individuals themselves who gain their own liberation. What the state ought to do is to make sure that the individuals who want to move themselves, advance themselves, liberate themselves have the opportunity to do so. Therefore, the state should provide the information, the resources and protection from other people's actions—the stick hitting your nose, as the Chairman said.

Q107 John Austin: So the prime responsibility is with the government for creating—
Dr Reid: No, the primary responsibility, and I would go further: the primary dynamo of social change is the individual.

Q108 Mr Amess: You have gone very quiet, Secretary of State! I am the individual. If I could just make—
Dr Reid: Could I just tell you why, briefly? In a free society you can give all the information, all the advice, all the prohibition, as they tried in the United States on drink, you can use it all but ultimately in a free society you cannot force people to eat healthily. You cannot force people unless you get rid of the free society. Now, that is why—

Q109 John Austin: But you can create the conditions which enable them to eat healthily.

Dr Reid: Absolutely. Of course, I entirely agree with you and that is why I say the job of the state is to make sure that you have as much opportunity as everyone else to advance yourself, to educate yourself or to make yourself healthy, but it is ultimately you, Mr Austin, who will decide, it is not the state. That is why I said in short at the Labour Party Conference when you define in Latin, as I remember from school, it did not say, "I choose. You choose. They get determined," it says, "I choose. You choose. They choose." That is just where I come from on this and I believe it is where the Government comes from, and I believe what we did in the Public Health White Paper reflects our view of society, which is that it is ordinary individuals, ordinary working people and their families who create their own advance, get their own jobs, and so on, but we help them through the new deal. As one woman in Dundee said to me when I said, "I'm really glad we were able to get you the job," she said, "John, I got the job myself. You gave me the opportunity to do it," and what we are doing is giving people the opportunity to live a healthy lifestyle.

Q110 Dr Naysmith: Can I just ask the Secretary of State for his reflections on why safety belt legislation has been one of the most successful public health measures ever introduced?
Dr Reid: It has been because we made it compulsory, yes, but that is not the point. The point is that that was a degree of compulsion in society which was acceptable to people.

Q111 Dr Naysmith: You tried it voluntarily first and it did not work.
Dr Reid: If you wanted to stop the 120,000 people in this country who die from smoke-related deaths you would ban smoking and make it illegal; you would make it a criminal offence. If you wanted to stop the 120,000 people who die from coronary-related disease you would make certain foods illegal and you would probably make alcohol illegal as well if you wanted to do that, but in a free society that is not tolerable and I have been careful in what I have said. I have said that in any free society the balance between the state and the individual is that the individual should through their own efforts liberate themselves but it is the role of the state to make sure that everybody has an equal opportunity to do that. Now, I was asked for my view by Mr Austin and I have given it.

Q112 Mr Amess: I think I should be in favour of what you have just said—
Dr Reid: The whole country should.

Q113 Mr Amess: — but I am going to reflect on this. I am so shocked by it!
Dr Reid: The whole country should be voting New Labour!

Q114 Mr Amess: Oh, dear, oh, dear, let us hope for God's sake they do not! As far as Primary Care Trusts are concerned, I look forward to the delivery

of all these aspirations that you have. I am a tiny bit frustrated because I have been trying to hear from the chief executive of my Primary Healthcare Trust since, I think, about September and October about all the initiatives. We seem to have endless meetings cancelled, indeed you mentioned Sir Nigel Crisp earlier and he was used as the reason for the latest cancellation of a meeting on Friday. I would just simply say this to you—and I know your Minister for Public Health will be fed up with my mentioning the Obesity Awareness Solutions Trust—I am very concerned about who is being charged to deliver these things. I think it is very unfortunate that they have had their funding withdrawn under section 64 and I met yesterday a great group of people from the "Get Fit Foundation" who are doing absolutely wonderful work. They are trying to get the Prime Minister to budge on this and again they are a bit frustrated because of the funding issue. So I think it is great to hear all the aspirations and delivery but I am now slightly concerned about who is being charged to deliver your aspirations, but I know you are going to write to us with more details.

Dr Reid: We will write to you with the plan, but basically we are moving towards—if you look at the Department of Health and the health service as a whole we are in transition, some people would say a revolution in transformation. Let us forget whether everybody likes the changes or not. There is certainly huge change going on and the centre which for generations has dictated and micro-managed to some extent everything is moving back and the power is moving to the front line, indeed beyond the front line to individuals themselves, but there will be certain things kept at the centre, the provision of finance from general taxation because we are committed to that as a National Health Service, the custodianship of the founding principle of the National Health Service, which is the delivery of health care free at the point of need and we will protect that, so people are not free to get rid of that, and certain other thing will include the strategic direction of health care and I think also the strategic direction of public health. So I think that we will at the centre, as we pass a lot of the treatment and sickness powers down, take on a greater role for public health but it will not be dictating to individuals but rather empowering them through giving them all the opportunity by changing social circumstances, by giving them more resources at a local level, by giving them more advice and information like food labelling, by giving them assistance like lifting the phone to Health Direct (which will follow on from NHS Direct), by giving them personal trainers, and so on, so that we will enable people on the ground through a local delivery (which is your PCTs) the strategic direction being set from the centre. Now, the details of that we will send to you. We are moving down from the strategic through the operational to the tactical and as they are laid out we will send them to the Committee, Chairman.

Q115 Chairman: Thank you, colleagues. Can I thank our witnesses, Secretary of State, Minister and Dr Adshead for a very useful session.

Dr Reid: Can we genuinely thank you and your colleagues. Just before you go, we were preparing for this and one of the questions which was asked, Mr Hinchliffe, we anticipated, about Derek Wanless. Derek Wanless was of great assistance to us, as was the great British public in this, as was, in other questions asked, the Chief Medical Officer, but I decided then that if asked why did we not follow the advice of this or that I was going to say that there were many inputs into this and if it is in any way a success on this occasion—there have been many fathers and one of them has been your Committee—I genuinely believe that as I have looked back at the relationships the Secretaries of State have had with various committees I think that the formation, the influence and the input into this of your discussions over some years has been probably as heavy and influential as anything I have known a Select Committee to do. So thank you for everything you have done.

Chairman: Thank you for your comments.

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